Office of Minority Health
U.S. Department of Health and Human Services

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

A Blueprint for Advancing and Sustaining CLAS Policy and Practice

April 2013

OMH
U.S. Department of Health and Human Services
Office of Minority Health

THINK CULTURAL HEALTH

MH13D11824

Office of Minority Health Resource Center
Knowledge Center
1101 Wootton Parkway, Suite 650
Rockville, MD 20852
1-800-444-6472

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care:

A Blueprint for Advancing and Sustaining CLAS Policy and Practice

Office of Minority Health
U.S. Department of Health and Human Services

April 2013

Office of Minority Health Resource Center
Knowledge Center
1101 Wootton Parkway
Rockville, MD 20852
1-800-444-6472

Table of Contents

ACKNOWLEDGMENTS **7**

EXECUTIVE SUMMARY **8**

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care 14

THE CASE FOR THE ENHANCED NATIONAL CLAS STANDARDS **15**

Respond to Demographic Changes 16
Eliminate Health Disparities 17
Improve Quality of Services and Care 18
Meet Legislative, Regulatory, and Accreditation Mandates 19
Gain a Competitive Edge in the Market Place 20
Decrease the Risk of Liability 21

THE ENHANCED NATIONAL CLAS STANDARDS **22**

The Standards 22
Purpose 22
Audience 22
Components of the Standards 24
Strategies for Implementation 24

ENHANCEMENTS TO THE NATIONAL CLAS STANDARDS **26**

Culture 26
Health 29
Health and Health Care Organizations 29
Individuals and Groups 29
Statement of Intent 30
Clarity and Action 31
Standards of Equal Importance 31
Principal Standard and Three Enhanced Themes 33
New Standard: Organizational Governance and Leadership 35

LOOKING AHEAD: THE FUTURE AND THE NATIONAL CLAS STANDARDS **36**

Continued Enhancements 36
State and Federal Legislation 36
Support and Guidance 37

BIBLIOGRAPHY **38**

THE BLUEPRINT **45**

STANDARD 1: PROVIDE EFFECTIVE, EQUITABLE, UNDERSTANDABLE, AND RESPECTFUL QUALITY CARE AND SERVICES....46

Standard 1....46
Purpose....46
Components of the Standard....46
Strategies for Achievement of the Principal Standard....50
Resources....51
Bibliography....52

STANDARD 2: ADVANCE AND SUSTAIN GOVERNANCE AND LEADERSHIP THAT PROMOTES CLAS AND HEALTH EQUITY....55

Standard 2....55
Purpose....55
Components of the Standard....55
Strategies for Implementation....59
Resources....60
Bibliography....60

STANDARD 3: RECRUIT, PROMOTE, AND SUPPORT A DIVERSE GOVERNANCE, LEADERSHIP, AND WORKFORCE....63

Standard 3....63
Purpose....63
Components of the Standard....63
Strategies for Implementation....65
Resources....66
Bibliography....67

STANDARD 4: EDUCATE AND TRAIN GOVERNANCE, LEADERSHIP, AND WORKFORCE IN CLAS....69

Standard 4....69
Purpose....69
Components of the Standard....69
Strategies for Implementation....72
Resources....73
Bibliography....74

STANDARD 5: OFFER COMMUNICATION AND LANGUAGE ASSISTANCE....76

Standard 5....76
Purpose....76
Components of the Standard....76
Strategies for Implementation....80

Resources....80
Bibliography....81

STANDARD 6: INFORM INDIVIDUALS OF THE AVAILABILITY OF LANGUAGE ASSISTANCE....83

Standard 6....83
Purpose....83
Components of the Standard....83
Strategies for Implementation....85
Resources....87
Bibliography....88

STANDARD 7: ENSURE THE COMPETENCE OF INDIVIDUALS PROVIDING LANGUAGE ASSISTANCE....89

Standard 7....89
Purpose....89
Components of the Standard....89
Strategies for Implementation....92
Resources....94
Bibliography....95

STANDARD 8: PROVIDE EASY-TO-UNDERSTAND MATERIALS AND SIGNAGE....97

Standard 8....97
Purpose....97
Components of the Standard....97
Strategies for Implementation....100
Resources....100
Bibliography....101

STANDARD 9: INFUSE CLAS GOALS, POLICIES, AND MANAGEMENT ACCOUNTABILITY THROUGHOUT THE ORGANIZATION'S PLANNING AND OPERATIONS....103

Standard 9....103
Purpose....103
Components of the Standard....103
Strategies for Implementation....104
Resources....105
Bibliography....106

STANDARD 10: CONDUCT ORGANIZATIONAL ASSESSMENTS....107

Standard 10....107
Purpose....107
Components of the Standard....107

Strategies for Implementation 109
Resources 110
Bibliography 111

STANDARD 11: COLLECT AND MAINTAIN DEMOGRAPHIC DATA 113

Standard 11 113
Purpose 113
Components of the Standard 113
Strategies for Implementation 119
Resources 120
Bibliography 121

STANDARD 12: CONDUCT ASSESSMENTS OF COMMUNITY HEALTH ASSETS AND NEEDS 124

Standard 12 124
Purpose 124
Components of the Standard 124
Strategies for Implementation 126
Resources 128
Bibliography 129

STANDARD 13: PARTNER WITH THE COMMUNITY 130

Standard 13 130
Purpose 130
Components of the Standard 130
Strategies for Implementation 131
Resources 132
Bibliography 133

STANDARD 14: CREATE CONFLICT AND GRIEVANCE RESOLUTION PROCESSES 135

Standard 14 135
Purpose 135
Components of the Standard 135
Strategies for Implementation 137
Resources 137
Bibliography 138

STANDARD 15: COMMUNICATE THE ORGANIZATION'S PROGRESS IN IMPLEMENTING AND SUSTAINING CLAS 139

Standard 15 139
Purpose 139
Components of the Standard 139

Strategies for Implementation 140
Resources 142
Bibliography 142

APPENDIX A: GLOSSARY 144

Bibliography 157

APPENDIX B: NATIONAL CLAS STANDARDS ENHANCEMENT INITIATIVE 164

Background 164
Goals 164
Development Process 165
Public Comment 166
National Project Advisory Committee 167

APPENDIX C: NATIONAL PROJECT ADVISORY COMMITTEE 170

APPENDIX D: CROSSWALK — NATIONAL CLAS STANDARDS 2000 AND 2012 173

APPENDIX E: RESOURCES 177

List of Figures and Tables

Figure 1: State Legislation 19

Figure 2: Interrelationship of Aspects of Culture 28

Figure 3: Enhanced National CLAS Standards' Themes 33

Figure 4: Phases of the National CLAS Standards Enhancement Initiative 165

Figure 5: Advisory Committee Meetings 167

Table 1: Blueprint Chapter Structure 45

Table 2: Examples of Promoting CLAS Through Policy and Practice 57

Table 3: Interpreting and Translating 77

Table 4: A Process for Collecting Data 119

Acknowledgments

This document is the result of a multiyear process that involved many individuals across the country. We extend our appreciation to them:

- The National Project Advisory Committee (Advisory Committee) members, for their generosity in sharing their time and expertise and their tireless dedication in the review of numerous drafts of terminology, documents, and the enhanced National CLAS Standards. A complete list of the Advisory Committee members appears in Appendix C.
- The individuals and organizations who participated in the public comment period, either by attending a public comment meeting or by providing online or written submissions. Your input helped to inform the enhancements to the National CLAS Standards, originally released in 2000.

Executive Summary

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health [OMH], 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization [WHO], 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion [ODPHP], 2010a). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). There are numerous ethical and practical reasons why providing culturally and linguistically appropriate services in health and health care is necessary, including the following, which have been identified by the National Center for Cultural Competence (Cohen & Goode, 1999, revised by Goode & Dunne, 2003):

1. To respond to current and projected demographic changes in the United States.
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
3. To improve the quality of services and primary care outcomes.
4. To meet legislative, regulatory and accreditation mandates.
5. To gain a competitive edge in the market place.
6. To decrease the likelihood of liability/malpractice claims.

The six reasons for the implementation of cultural competency as described by the National Center for Cultural Competence fall into two frequently cited overarching philosophies: one that pertains to social justice and the other that pertains to standards of business. The social justice philosophy emphasizes diversity and the improvement of services to underserved populations, while the standards of business philosophy focuses on strengthening business practices and business development.

The enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, known as the enhanced National CLAS Standards, from the Office of Minority Health at the U.S. Department of Health and Human Services are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (National Partnership for Action to End Health Disparities, 2011a), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Adoption of these Standards will help advance better health and health care in the United States.

The enhanced National CLAS Standards are built upon the groundwork laid by the original National CLAS Standards, developed in 2000 by the HHS Office of Minority Health. The original National CLAS Standards provided guidance on cultural and linguistic competency, with the ultimate goal of reducing racial and ethnic health care disparities. Over the past decade, the original National CLAS Standards have served as catalyst and conduit for efforts to improve the quality of care and achieve health equity (e.g., Diamond, Wilson-Stronks, & Jacobs, 2010; Joint Commission, 2010; Kairys & Like, 2006).

The HHS Office of Minority Health undertook the National CLAS Standards Enhancement Initiative from 2010 to 2012 to recognize the nation's increasing diversity, to reflect the tremendous growth in the fields of cultural and linguistic competency over the past decade, and to ensure relevance with new national policies and legislation, such as the Affordable Care Act. A decade after the publication of the original National CLAS Standards, there is still much work to be done. Racial and ethnic disparities in health and health care remain a significant public health issue, despite advances in health care technology and delivery, even when factors such as insurance coverage, income, and educational attainment are taken into account (American College of Physicians, 2010; Griffith, Yonas, Mason, & Havens, 2010). Cultural and linguistic competency strives to

improve the quality of care received and to reduce disparities experienced by racial and ethnic minorities and other underserved populations (Saha, Beach, & Cooper, 2008). Through the National CLAS Standards Enhancement Initiative, a new benchmark is being established for culturally and linguistically appropriate services to improve the health of all individuals.

The National CLAS Standards Enhancement Initiative's development process, described in detail in Appendix B, was informed by three primary sources: public comment, a National Project Advisory Committee, and a systematic literature review. These three sources of data informed the scope and direction of the Enhancement Initiative, and, ultimately, the enhanced National CLAS Standards. For example, the majority of public comments indicated that while the original National CLAS Standards met the intended needs as a whole, additional context was needed regarding the Standards' focus and purpose, as well as more clearly defined key terminology. Additional comments suggested that the organizations targeted for implementing the National CLAS Standards should be expanded and that additional guidance regarding implementation should be provided.

The data collected from public comment, the National Project Advisory Committee, and the systematic literature review showed strong support for expanding the key concepts of culture and health, which serve as the conceptual underpinnings of the National CLAS Standards. Adopting a more comprehensive conceptualization of health requires, by extension, a more inclusive recognition of the variety of professionals and organizations providing the related care and services. The enhancements related to this are as follows:

- ***Culture*** is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes. This definition is adapted from other widely accepted definitions of culture (i.e., Gilbert, Goode, & Dunne, 2007; HHS OMH, 2005) and attempts to reflect the complex nature of culture, as well as the various ways in which culture has been defined and studied across multiple disciplines.
- ***Health*** is understood to encompass many aspects, including physical, mental, social, and spiritual well-being (HHS Indian Health Services [IHS], n.d.; HHS Office of the Surgeon General [OSG] & National Action Alliance for Suicide Prevention, 2012; WHO, 1946). The World Health Organization also notes that health is "not merely the

absence of disease or infirmity" (WHO, 1946). Health status occurs along a continuum and therefore can range from poor to excellent. The advancement of health equity allows individuals to experience better health over the course of their life spans.

- ***Audience*** The enhanced National CLAS Standards reference both health and health care organizations to acknowledge those working not only in health care settings, such as hospitals, clinics, and community health centers, but also in organizations that provide services such as behavioral and mental health, public health, emergency services, and community health. Any organization addressing individual or community health, health care, or well-being can benefit from the adoption and implementation of the National CLAS Standards.

  To further reflect the more inclusive nature of the enhanced National CLAS Standards, the enhanced Standards use the terminology *individuals and groups* in lieu of *patients and consumers*. *Individuals and groups* encompass patients, consumers, clients, recipients, families, caregivers, and communities. Therefore, the term *individuals and groups* includes anyone receiving services from a health or health care organization.

Thus, the enhanced National CLAS Standards incorporate broader definitions of culture and health and aim to reach a broader audience, in an effort to ensure that every individual has the opportunity to receive culturally and linguistically appropriate health care and services.

The data collected from public comment, the National Project Advisory Committee, and the systematic literature review also informed several enhancements to the structure and content of the National CLAS Standards, as follows (see Appendix D for a comparison between the original and enhanced National CLAS Standards):

- ***Statement of Intent:*** The enhanced National CLAS Standards include an introductory statement:

  "The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:"

  The addition of the statement of intent ties the culturally and linguistically competent policies and practices posed in the enhanced National CLAS Standards directly to the goals of advancing health equity, improving quality, and eliminating health care disparities.

- ***Clarity and Action:*** Each of the National CLAS Standards was revised for greater clarity and focus. In addition, the wording of each of the 15 Standards now begins with an action word to emphasize how the desired goal may be achieved.
- ***Standards of Equal Importance:*** The original National CLAS Standards designated each Standard as a recommendation, mandate, or guideline. The enhanced National CLAS Standards, however, promote collective adoption of all Standards to promote optimal health and well-being of all individuals. Each of the 15 Standards should be viewed as an equally important guideline to advance health equity, improve quality, and help eliminate health care disparities.
- ***Principal Standard and Three Enhanced Themes:*** The enhanced Standards have been reorganized to address feedback obtained from the Enhancement Initiative and to improve their overall intention, clarity, and practicality. The enhanced National CLAS Standards elevate the previous Standard 1 to the status of Principal Standard and reframe the three themes. The names of the three themes have been updated both to clarify intent and to broaden the scope of their interpretation and application.
    - *Principal Standard:* Standard 1 has been made the Principal Standard with the understanding that it frames the essential goal of all of the Standards, and if the other 14 Standards are adopted, implemented, and maintained, then the Principal Standard will be achieved.
    - *Theme 1:* Governance, Leadership, and Workforce — Changing the name of Theme 1 from *Culturally Competent Care* to *Governance, Leadership, and Workforce* provides greater clarity on the specific locus of action for each of these Standards and emphasizes the importance of CLAS implementation as a systemic responsibility, requiring the endorsement and investment of leadership, and the support and training of all individuals within an organization.
    - *Theme 2:* Communication and Language Assistance — Changing the name of Theme 2 from *Language Access Services* to *Communication and Language Assistance* broadens the understanding and application of appropriate services to include all communication needs and services, e.g., sign language, braille, oral interpretation, and written translation.
    - *Theme 3:* Engagement, Continuous Improvement, and Accountability — Changing the name of Theme 3 from *Organizational Supports* to *Engagement, Continuous Improvement, and Accountability* underscores the importance of establishing individual responsibility for ensuring that CLAS is supported, while

maintaining that effective delivery of CLAS demands action across organizations.

- ***New Standard: Organizational Governance and Leadership:*** The enhanced National CLAS Standards emphasize the importance of CLAS being integrated throughout an organization. This requires a bottom-up and a top-down approach to advancing and sustaining CLAS. Organizational governance and leadership are key to ensuring the successful implementation and maintenance of CLAS. In recognition of this, the enhanced National CLAS Standards include a new Standard focused on the role of governance and leadership as it relates to CLAS. A complete list of all 15 enhanced National CLAS Standards, including the new Standard, can be found at the end of this executive summary.

This document, the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (*The Blueprint*), offers a user-friendly format for providing comprehensive — but by no means exhaustive — information on each Standard. *The Blueprint* is an implementation guide for advancing and sustaining culturally and linguistically appropriate services within health and health care organizations. *The Blueprint* dedicates one chapter to each of the 15 Standards. These chapters review the Standard's purpose, components, and strategies for implementation. In addition, each chapter provides a list of resources that provide additional information and guidance on that Standard.

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Case for the Enhanced National CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (HHS OMH, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (WHO, 2012), such as socioeconomic status, education level, and the availability of health services (HHS ODPHP, 2010a). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most changeable factors is the lack of culturally and linguistically appropriate services.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist et al., 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode et al., 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

There are numerous ethical and practical reasons why providing culturally and linguistically appropriate services in health and health care is necessary. The following reasons have been identified by the National Center for Cultural Competence (Cohen & Goode, 1999, revised by Goode & Dunne, 2003):

1. To respond to current and projected demographic changes in the United States.
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
3. To improve the quality of services and primary care outcomes.
4. To meet legislative, regulatory and accreditation mandates.
5. To gain a competitive edge in the market place.
6. To decrease the likelihood of liability/malpractice claims.

The motivations for implementing CLAS are as varied as the approaches different stakeholders are taking toward implementation, and depend upon the stakeholder's mission, goals, and sphere of influence (Betancourt, Green, Carrillo, & Park, 2005). The six reasons for the implementation of cultural competency as described by the National Center for Cultural Competence fall into two frequently cited overarching philosophies: one that pertains to social justice (e.g., Kumagai & Lypson, 2009; Sue, 2001) and the other that pertains to standards of business (Brach & Fraser, 2002). Specifically, reasons number one and number two are consistent with the social justice philosophy, which emphasizes diversity and the improvement of services to underserved populations. The remaining reasons are consistent with the standards of business philosophy, which focuses on strengthening business practices and business development.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (National Partnership for Action to End Health Disparities, 2011a), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

The following sections expound upon the reasons why culturally and linguistically appropriate services in health and health care are necessary, as listed by the National Center for Cultural Competence.

Respond to Demographic Changes

It is projected that by 2050 the U.S. demographic makeup will be 47% non-Hispanic White, 29% Hispanic, 13% Black and 9% Asian (Passel & Cohn, 2008). According to the most recent data, approximately 20% of the U.S. population, or a little over 58 million people, speak a language other than English at home, and of that 20%, almost 9% (over 24 million people) have limited proficiency in English (Au, Taylor, & Gold, 2009; U.S. Census Bureau, 2010), which has implications for their proficiency in health and health care (The Joint Commission, 2010). Given the increasing cultural diversity over the last several decades (e.g., Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003; Goode et al., 2006) and the rapidly changing landscape of health and health care in the United

States (Chin, 2000), there is an increased need for health and health care professionals and organizations to provide effective, high-quality care that is responsive to the diverse cultural and linguistic needs of individuals served.

The need for culturally and linguistically appropriate care is particularly great since similar demographic changes have not occurred in the health and health care workforce (e.g., Genao et al., 2003; Institute of Medicine [IOM], 2004; Sullivan & Mittman, 2010). Given the important role that culture plays in health and health behaviors (Kleinman, Eisenberg, & Good, 1978; Tseng & Streltzer, 2008), the lack of workforce diversity is significant since it widens the cultural gap that already exists between health and health care professionals and consumers, which subsequently contributes to the persistence of health disparities (Brach & Fraser, 2000; Genao et al., 2003). The provision of culturally and linguistically appropriate services can help to bridge this gap.

Eliminate Health Disparities

The prevalence of health disparities has been well-documented. For example, racial and ethnic minorities have disproportionately higher rates of chronic disease and disability, higher mortality rates, and lower quality of care, compared to non-Hispanic whites (e.g., Health Research & Educational Trust [HRET], 2011; IOM, 2003). In addition, even with expanded insurance coverage, racial minorities are less likely to receive needed behavioral health services comparable to non-Latino Whites (Alegria, Lin, Chen, Duan, Cook, & Meng, 2012). Health disparities exist beyond racial and ethnic groups; for example, individuals with lower incomes are more likely to experience preventable hospitalizations compared to individuals with higher incomes (HHS Centers for Disease Control and Prevention [CDC], 2011). In addition, lesbian women are less likely to receive preventative cancer screenings than their heterosexual counterparts (Buchmueller & Carpenter, 2010), and men who have sex with men are less likely to have access to health and behavioral health care than the general population of men (e.g., Alvy, McKirnan, DuBois, Ritchie, Fingerhut, & Jones, 2011; Buchmueller & Carpenter, 2010; McKirnan, DuBois, Alvy, & Jones, 2012).

The provision of culturally and linguistically appropriate services is increasingly recognized as a key strategy to eliminating disparities in health and health care (e.g., Betancourt, 2004; 2006; Brach & Fraser, 2000; HRET, 2011). Among several other factors, lack of cultural competence and sensitivity among health and health care professionals has been associated with the perpetuation of health disparities (e.g., Geiger, 2001; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). This is often the result of miscommunication and incongruence between the patient or consumer's cultural and linguistic needs and the

services the health or health care professional is providing (Zambrana, Molnar, Munoz, & Lopez, 2004). The provision of culturally and linguistically appropriate services can help address these issues by providing health and health care professionals with the knowledge and skills to manage the provider-level, individual-level, and system-level factors referenced in the Institute of Medicine's seminal report *Unequal Treatment* that intersect to perpetuate health disparities (IOM, 2003).

Improve Quality of Services and Care

Health and health care professionals and organizations strive to provide high quality services that meet the needs of all the individuals they serve. High quality care and services are those provided respectfully and equitably to all populations served (American Medical Association [AMA], 2006; IOM, 2001). A commitment to high quality services and care is often reflected in organizations' mission statements or core values.

Culture influences health beliefs and practices, as well as health seeking behavior and attitudes (IOM, 2003). When health and health care professionals are aware of culture's influence on health beliefs and practices, they can use this awareness to consider and address issues such as access to care. This is just one example of how culturally and linguistically appropriate services can help improve health and health care quality (Betancourt, 2006). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of services (Beach et al., 2004; Goode et al., 2006), increasing patient safety (e.g., through preventing miscommunication, facilitating accurate assessment and diagnosis), enhancing effectiveness, and underscoring patient-centeredness (e.g., Betancourt, 2006; Brach & Fraser, 2000; Thom, Hall, & Pawlson, 2004).

Meet Legislative, Regulatory, and Accreditation Mandates

Culturally and linguistically appropriate services are increasingly included in or referenced by local and national legislative, regulatory, and accreditation mandates. For example, the Patient Protection and Affordable Care Act (the Affordable Care Act), Pub. L. No. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2012, Pub. L. No. 111-152 (2012), referred to collectively as the Affordable Care Act, contains several provisions related to culturally and linguistically appropriate services.

denotes legislation requiring (WA, CA, CT, NJ, NM) or strongly recommending (MD) cultural competence training that was signed into law
denotes legislation that has been referred to committee and is currently under consideration
denotes legislation that died in committee or was vetoed

Figure 1: State Legislation

Section 1311(i)(3)(E) of the Affordable Care Act requires that outreach and education efforts by Navigators – entities that receive grants from health insurance exchanges created under the Affordable Care Act to assist individuals in accessing and taking advantage of the exchanges – be culturally and linguistically appropriate. Furthermore, under sections 2715 and 2719 of the Public Health Service Act as amended by the Affordable Care Act, insurance companies are required to provide certain disclosures and notices in a culturally and linguistically appropriate manner.

In addition, under Title VI of the Civil Rights Act of 1964, as implemented by Executive Order 13166, organizations receiving federal funds must take reasonable steps to provide meaningful access to their programs for individuals with limited English proficiency (Executive Order no. 13,166, 2000). Furthermore, several states have recognized the importance of cultural and linguistic competency by legislating cultural and linguistic competency training in health care. These mandates help state health agencies incorporate cultural and linguistic competency into the health services they provide. As of 2012, six states have moved to mandate some form of cultural and linguistic competency for either all or a component of its health care workforce (see Figure 1) (HHS OMH Think Cultural Health, 2012).

Accrediting bodies such as The Joint Commission and the National Committee for Quality Assurance have established accreditation standards that target the improvement of communication, cultural competency, patient-centered care, and the provision of language assistance services (Briefer French, Schiff, Han, & Weinick, 2008; Wilson-Stronks & Galvez, 2007).

Gain a Competitive Edge in the Market Place

Culturally and linguistically appropriate services can also help health and health care professionals and organizations gain a competitive edge in the market place. Although the implementation of culturally and linguistically appropriate services certainly requires resources, there are numerous business-related advantages to investing these resources. By implementing culturally and linguistically appropriate services – including the provision of communication and language assistance, as well as partnerships with the community – an organization can develop a positive reputation in the service area and therefore expand its market share. The provision of effective, equitable, understandable, and respectful quality care and services helps cultivate a loyal consumer base, which then solidifies this market share (AMA, 2006).

As the American Medical Association notes, "a loyal consumer base helps organizations avoid costly problems, such as high turnover, low utilization rates, and unused capacity" (AMA, 2006, p. 112). In addition, culturally and linguistically appropriate services, such as assessments of community health assets and needs, help organizations tailor their services, making the services more cost-effective (e.g., Hornberger, Itakura, & Wilson, 1997).

Overall, culturally and linguistically competent practices can help organizations gain a competitive edge in the market place, as illustrated in the following examples (Alliance of Community Health Plans Foundation, 2007):

- Holy Cross Hospital in Maryland increased its market share among individuals with limited English proficiency by creating 68 individual maternity suites with a substantial cultural competency component in their design. Deliveries at the maternity suites increased from 7,300 to 9,300 annually.
- Contra Costa Health Services in California implemented a Remote Video/Voice Medical Interpretation Project, which increased the overall effectiveness of interpretation services. With the addition of this service, the hospital serves twice

the number of patients it did before the service was available, and for significantly lower costs.

Decrease the Risk of Liability

The literature illustrates the vital role communication plays in avoiding cases of malpractice due to diagnostic and treatment errors (Goode et al., 2006). When communicating with culturally and linguistically diverse populations, the opportunity for miscommunication and misunderstanding increases, which subsequently increases the likelihood of errors (Youdelman & Perkins, 2005). These errors, in turn, can cost millions of dollars in liability or malpractice claims. Culturally and linguistically appropriate services can reduce the possibility of such errors. For example, a first responder in Florida misinterpreted a single Spanish word, "intoxicado," to mean "intoxicated" rather than its intended meaning of "feeling sick to the stomach." This led to a delay in diagnosis, which resulted in a potentially preventable case of quadriplegia, and ultimately, a $71 million malpractice settlement (Flores, 2006).

The HHS Health Resources and Services Administration [HRSA] found that health professionals who lack cultural and linguistic competency can be found liable under tort principles in several areas (2005). For instance, providers may be presumed negligent if an individual is unable to follow guidelines because they conflict with his/her beliefs and the provider neglected to identify and try to accommodate the beliefs (HRSA, 2005). Additionally, if a provider proceeds with treatment or an intervention based on miscommunication due to poor quality language assistance, he/she and his/her organization may face increased civil liability exposure (DeCola, 2010). Thus, culturally and linguistically appropriate communication is essential to minimize the likelihood of liability and malpractice claims.

The Enhanced National CLAS Standards

The Standards

The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care from the Office of Minority Health at the U.S. Department of Health and Human Services are composed of 15 Standards that provide individuals and organizations with a blueprint for successfully implementing and maintaining culturally and linguistically appropriate services. Culturally and linguistically appropriate health care and services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, are increasingly seen as essential to reducing disparities and improving health care quality.

All 15 Standards are necessary to advance health equity, improve quality, and help eliminate health care disparities. As important as each individual Standard is, the exclusion of any Standard diminishes health professionals' and organizations' ability to meet an individual's health and health care needs in a culturally and linguistically appropriate manner. Thus, it is strongly recommended that each of the 15 Standards be implemented by health and health care organizations.

Purpose

The purpose of the enhanced National CLAS Standards is to provide a blueprint for health and health care organizations to implement culturally and linguistically appropriate services that will advance health equity, improve quality, and help eliminate health care disparities.

Audience

All members of the health and health care community can benefit from the framework offered by the enhanced National CLAS Standards. The enhanced National CLAS Standards are directed toward a broader audience than the original Standards in order to address more fully every point of contact throughout the health care and health services continuum. A wide spectrum of professionals and organizations influence health and health care every day. The following is a partial list of audiences of the enhanced National CLAS Standards and how each type of audience might utilize them:

- ***Accreditation and Credentialing Agencies:*** to assess and compare health care facilities, health and human service organizations, and providers who offer culturally

and linguistically appropriate services and ensure quality for diverse populations. Institutions such as The Joint Commission and the National Committee for Quality Assurance have made great strides in implementing policies and standards to help ensure these quality services.

- ***Community-Based Organizations:*** to promote quality health care for diverse populations and to assess and monitor care and services being delivered. The potential advocate audience is broad and includes: legal services, consumer education agencies, faith-based organizations, and other local, regional, or national nonprofit organizations that address health and health care issues.
- ***Educators:*** to incorporate cultural and linguistic competency into their curricula and to raise awareness about the impact of culture and language on health and health care services. This audience would include educators from academic institutions, state health professional licensing agencies, and educators from legal and social service professions.
- ***Governance and Leadership:*** to draft consistent and comprehensive laws, regulations, and contract language. This audience would include federal, state, tribal, and local governments. The audience would also include the individuals within organizations who are responsible for developing regulations and contracts, as well as the leadership responsible for decision making regarding regulations and contracts.
- ***Health Care and Service Providers:*** to incorporate cultural and linguistic competency into the delivery of quality health care and services. This audience would include clinicians, practitioners, and service delivery organizations across health and allied health disciplines, including behavioral health.
- ***Health and Health Care Staff and Administrators:*** to implement culturally and linguistically appropriate services throughout an organization, at every point of contact. This audience would include employees, contractors, and volunteers serving throughout the organization.
- ***Patients/Consumers:*** to understand their right to receive accessible and appropriate health and health care services and to evaluate whether providers can offer them.***Public Health Workforce:*** to implement cultural and linguistic competency into the provision of public health services. This audience would include those involved in the behavioral health, emergency medical services, environmental health, epidemiology, and global health.

- ***Purchasers:*** to promote the needs of diverse consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits.

Components of the Standards

The enhanced National CLAS Standards are built upon the groundwork laid by the original Standards developed in 2000. The enhanced Standards incorporate broader definitions of culture and health and aim to reach a broader audience, in an effort to ensure that every individual has the opportunity to receive culturally and linguistically appropriate health care and services.

The enhanced National CLAS Standards are organized into one Principal Standard and three themes: (1) Governance, Leadership, and Workforce; (2) Communication and Language Assistance; and (3) Engagement, Continuous Quality Improvement, and Accountability. Individuals and organizations may identify or utilize additional standards that are relevant to their mission and services and are encouraged to add to the National CLAS Standards.

Strategies for Implementation

Implementation of the National CLAS Standards will vary from organization to organization. Therefore, organizations should identify the best implementation methods appropriate to their size, mission, scope, and type of services offered. It is also important to develop measures to examine the effectiveness of the programs being implemented, identify areas for improvement, and identify next steps. Many of these measures and evaluation strategies may already be in place throughout an organization for the purposes of accreditation and grant management. Health and human service providers, emergency responders, community-based organizations, and health care delivery sites (e.g., hospitals, clinics, and community health centers) will have different goals and expectations for the National CLAS Standards. Therefore, their strategies for implementation may differ widely.

The enhanced National CLAS Standards and *The Blueprint* include specific implementation strategies to further the establishment or expansion of culturally and linguistically appropriate services. Prior to implementation, it is important to have a vision of what culturally and linguistically appropriate services would look like within the organization and to identify available and required resources (e.g., structure, funding, and personnel) to ensure success.

Responsibilities associated with implementing the enhanced National CLAS Standards should be distributed throughout the organization to ensure comprehensive engagement and effectiveness so that no single individual or department bears the responsibility for the entire organization. For example, some organizations find it helpful to establish an interdisciplinary or cross-departmental committee that will help identify, implement, and sustain the elements of a well-developed CLAS plan.

Enhancements to the National CLAS Standards

Data collected during the HHS Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care Enhancement Initiative supported the notion that it was time for an enhancement of the original National CLAS Standards. In the beginning stages of the Enhancement Initiative, a majority of individuals who provided public comment on the original National CLAS Standards indicated that though the Standards met their needs as a whole, additional guidance or direction was needed.

More specifically, individuals and organizations who provided public comment sought clarification on the Standards' intention, terminology, and implementation strategies. There was also strong support, from public comment, the Advisory Committee, and a literature review, for expanding the concepts of health and culture. The enhanced National CLAS Standards and *The Blueprint* aim to address these issues. The format of *The Blueprint* reflects the suggestions provided during the public comment period.

The past decade has shown that the National CLAS Standards are dynamic in nature. Therefore, as best and promising practices develop in the field of cultural and linguistic competency, there will be future enhancements of the National CLAS Standards. In addition, the Web version of *The Blueprint* will be updated periodically with additional information and resources as the Standards are disseminated in the field and as new information is gathered regarding promising implementation and management strategies.

The following sections discuss the enhancements made to the National CLAS Standards.

Culture

The enhanced National CLAS Standards have adopted an expanded, broader definition of culture. Specifically, in the enhanced National CLAS Standards, culture refers to "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics." This definition is adapted from other widely accepted definitions of culture (e.g., Gilbert et al., 2007; HHS OMH, 2005) and attempts to reflect the complex and dynamic nature of culture, as well as the numerous ways in which culture has been defined and studied across multiple disciplines. Refer to the table below for additional discussion of aspects of culture.

There is considerable recognition that every patient-provider interaction is a cross-cultural interaction and that the scope of cultural competency in health care should expand to address multiple markers of difference (Khanna, Cheyney, & Engle, 2009; IOM, 2003). The broader definition of culture adopted in the enhanced National CLAS Standards mirrors other leading initiatives in the field in terms of scope, including Healthy People 2020 from the Department of Health and Human Services (HHS ODPHP, 2010a) and The Joint Commission (*Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, 2010). In addition, with the recognition that culture includes multiple facets and markers of difference, there is an increased opportunity for health professionals to identify and use similarities to improve health and health care interactions.

Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime.

Elements of culture include, but are not limited to, the following:

- Age
- Cognitive ability or limitations
- Country of origin
- Degree of acculturation
- Educational level attained
- Environment and surroundings
- Family and household composition
- Gender identity
- Generation
- Health practices, including use of traditional healer techniques such as Reiki and acupuncture.
- Linguistic characteristics, including language(s) spoken, written, or signed; dialects or regional variants; literacy levels; and other related communication needs.
- Military affiliation
- Occupational groups
- Perceptions of family and community

- Perceptions of health and well-being and related practices
- Perceptions/beliefs regarding diet and nutrition
- Physical ability or limitations
- Political beliefs
- Racial and ethnic groups – including but not limited to — those defined by the U.S. Census Bureau.
- Religious and spiritual characteristics, including beliefs, practices, and support systems related to how an individual finds and defines meaning in his/her life.
- Residence (i.e., urban, rural, or suburban)
- Sex
- Sexual orientation
- Socioeconomic status

Individuals do not experience their lives or their health through a single lens of identity (e.g., solely race, gender, or religious); rather, many elements inform their perceptions, beliefs, customs, and reactions (e.g., Frable, 1997). Figure 2 depicts various aspects of culture through which an individual may frequently experience his/her cultural identity. For example, an individual's religious/spiritual characteristics often overlap with and are informed by the sociological and racial/ethnic groups with which he/she identifies (e.g., an African American Christian male may experience the world simultaneously by his race, sex, and religious beliefs). Each of the circles within Figure 2 represents a very broad area of culture, as described within the definition. These areas are by no means exhaustive, as there are many other aspects of cultural identity.

(Graves, 2001, revised 2011)

Figure 2: Interrelationship of Aspects of Culture

Health

Health encompasses many aspects, including physical, mental, social, and spiritual well-being (HHS IHS, n.d.; HHS OSG et al., 2012; WHO, 1946). The World Health Organization also notes that health is "not merely the absence of disease or infirmity" (WHO, 1946). From this perspective, health status falls along a continuum and therefore can range from poor to excellent. In addition, how individuals experience health and define their well-being is greatly informed by their cultural identity. The advancement of health equity allows the attainment of the highest level of health for all people.

Health and Health Care Organizations

Adopting a more comprehensive conceptualization of health requires, by extension, a more inclusive recognition of the variety of professionals and organizations providing the related care and services. The enhanced National CLAS Standards reference both health *and* health care organizations and professionals to acknowledge those working not only in health care delivery facilities (e.g., hospitals, clinics, community health centers) but also in organizations that provide services such as behavioral and mental health, public health, emergency services, and community health and prevention. The National CLAS Standards are intended for use within all areas of health and human services.

This expansion also acknowledges the growing body of literature that pertains to the social determinants of health, defined by the World Health Organization as the "the conditions in which people are born, grow, live, work, and age, including the health system" and the role that social, economic, and environmental factors, such as socio-economic status and housing, play in health outcomes between different populations (WHO, 2012). The enhanced National CLAS Standards should be understood as applicable to hospitals or other health care delivery organizations as well as any public or private institution addressing individual, family, or community health, health care, or well-being.

Individuals and Groups

To further reflect the more inclusive nature of the enhanced National CLAS Standards, the enhanced Standards use the terminology *individuals and groups* in lieu of *patients and consumers*. *Individuals and groups* encompass patients, consumers, clients, recipients, families, caregivers, and communities.

Statement of Intent

In response to public comment and the National Project Advisory Committee feedback requesting further clarification on the intent of the National CLAS Standards, a statement of intent for the enhanced National CLAS Standards was crafted and has been added as an introductory statement to the Standards.

> The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

The addition of the intention statement ties the culturally and linguistically competent policies and practices posed in the enhanced National CLAS Standards directly to the goals of advancing health equity, improving quality, and eliminating health care disparities.

Advance Health Equity

Health equity is defined as the attainment of the highest level of health for all people (HHS OMH, 2011). Currently, many individuals are unable to attain their highest level of health for several reasons, including social factors such as inequitable access to quality care and individual factors such as limited resources. Lack of health equity has a significant economic and societal impact. Recent research on the economic burden of health inequality and health disparities found that:

- Approximately 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities (LaVeist et al., 2009).
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than $1 trillion (LaVeist et al., 2009).

Improve Quality

Culturally and linguistically appropriate services and related education initiatives affect several aspects of an organization's continuous quality improvement initiatives. For example, research suggests that after implementation of CLAS initiatives, there are substantial increases in provider knowledge and skill acquisition and improvements in provider attitudes toward culturally and linguistically diverse patient populations (Beach et al., 2004). Studies also indicate that patient satisfaction increases when culturally and linguistically appropriate services are delivered (Beach et al., 2004). At the organizational

level, hospitals and clinics that support effective communication by addressing CLAS have been shown to have higher patient-reported quality of care and more trust in the organization (Wynia, Johnson, McCoy, Passmore Griffin, & Osborn, 2010). Preliminary research has shown a positive impact of CLAS on patient outcomes (Lie, Lee-Rey, Gomez, Bereknyel, & Braddock, 2010), and a growing body of evidence illustrates the effectiveness of culturally and linguistically appropriate services in improving the quality of care and services received by individuals (Beach et al., 2004; Goode et al., 2006).

Help Eliminate Health Care Disparities

Eliminating health care disparities is one of the ultimate goals of advancing health equity. Disparities exist and persist across many culturally diverse groups, with individuals who identify as racial or ethnic minorities being less likely to receive preventive health services, even when insured (DeLaet, Shea, & Carrasquillo, 2002).

The following are a few selected findings featured in the HHS Agency for Healthcare Quality and Research [AHRQ] 2011 National Healthcare Quality Report and National Healthcare Disparities Report that highlight the disparities experienced by many in the United States (AHRQ, 2012a, 2012b):

- Access to quality health care remains suboptimal, particularly for minority and low-income groups.
- Despite improvements in quality, access and disparities have not improved.
- Certain services, geographic areas and populations were found to be in serious need of improvements in quality and progress in disparities reduction.

As the enhanced National CLAS Standards are disseminated, the inclusion of the statement of intent within the actual Standards ensures that every person who uses the Standards will understand their importance. Although this brief introductory statement cannot convey all the potential purpose(s) of the Standards, it does convey their primary goals.

Clarity and Action

Each of the National CLAS Standards was revised for greater clarity and focus. In addition, the wording of each of the 15 Standards now begins with an action word to emphasize how the desired goal may be achieved.

Standards of Equal Importance

The original National CLAS Standards designated each Standard as a recommendation, mandate, or guideline. The recommendation (original Standard 14) was a suggestion for

voluntary adoption by health care organizations. The mandates (original Standards 4, 5, 6, and 7) were Federal requirements for all recipients of Federal funds. The guidelines (original Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13) were activities recommended for adoption as mandates by Federal, State, and national accrediting agencies.

However, the enhanced National CLAS Standards promote collective adoption of all Standards as the most effective approach to improve the health and well-being of all individuals. The Standards are intended to be used together, as mutually reinforcing actions, and each of the 15 Standards should be understood as an equally important guideline to advance health equity, improve quality, and help eliminate health care disparities.

Although the enhanced National CLAS Standards do not represent statutory requirements, failure by a recipient of Federal financial assistance to provide services consistent with Standards 5 through 8 could result in a violation of Title VI of the Civil Rights Act of 1964 implementing regulation (See 42 USC 2000d et. Seq. and 45 CFR Part 80). Therefore, although Standards 5 through 8 do not represent legal requirements in all cases, implementation of these goals will help ensure that health care organizations and individual providers serve persons of diverse backgrounds in a culturally and linguistically appropriate manner and in accordance with the law. Advances in technology help health and human service organizations provide efficient and cost-effective language assistance services (Sperling, 2011). Health care organizations and individual providers are encouraged to seek technical assistance from the HHS Office for Civil Rights or review the *HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* document (HHS Office for Civil Rights [OCR], 2003) to assess whether or to what extent language access services must be provided in order to comply with the Title VI requirement to take reasonable steps to provide meaningful access to their programs for persons with limited English proficiency.

Principal Standard and Three Enhanced Themes

The enhanced Standards have been reorganized to address feedback gleaned from the Enhancement Initiative and to improve their overall intention, clarity, and practicality.

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (2012)
Principal Standard
Governance, Leadership, and Workforce
Communication and Language Assistance
Engagement, Continuous Improvement, and Accountability

Figure 3: Enhanced National CLAS Standards' Themes

The enhanced National CLAS Standards elevate the previous Standard 1 to the status of a Principal Standard, add a governance and leadership Standard as Standard 2, and reframe the three themes.[1]

The names of the three themes have been updated both to clarify intent and to broaden the scope of their interpretation and application.

Principal Standard

Standard 1 has been made the Principal Standard with the understanding that it frames the essential goal of all of the Standards, and if the other 14 Standards are adopted, implemented, and maintained, then the Principal Standard will be achieved.

1. Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Theme 1: Governance, Leadership, and Workforce

Changing the name of Theme 1 from *Culturally Competent Care* to *Governance, Leadership, and Workforce* provides greater clarity on the specific locus of action for each of these Standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization.

The Standards in this theme include:

[1] A crosswalk of the National CLAS Standards 2000 and 2012 may be found in Appendix D.

2. Advance and sustain governance and leadership that promotes CLAS and health equity

3. Recruit, promote, and support a diverse governance, leadership, and workforce

4. Educate and train governance, leadership, and workforce in CLAS

Theme 2: Communication and Language Assistance

Changing the name of Theme 2 from *Language Access Services* to *Communication and Language Assistance* broadens the understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation.

The Standards in this theme include:

5. Offer communication and language assistance

6. Inform individuals of the availability of language assistance

7. Ensure the competence of individuals providing language assistance

8. Provide easy-to-understand materials and signage

Theme 3: Engagement, Continuous Improvement, and Accountability

Changing the name of Theme 3 from *Organizational Supports* to *Engagement, Continuous Improvement, and Accountability* underscores the importance of establishing individual responsibility in ensuring that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands actions across an organization. This revision focuses on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one's role within an organization or practice. All individuals are accountable for upholding the values and intent of the National CLAS Standards.

The Standards in this theme include:

9. Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations

10. Conduct organizational assessments

11. Collect and maintain demographic data
12. Conduct assessments of community health assets and needs
13. Partner with the community
14. Create conflict and grievance resolution processes
15. Communicate the organization's progress in implementing and sustaining CLAS

New Standard: Organizational Governance and Leadership

Another theme that emerged from the feedback provided during the Enhancement Initiative was the importance of CLAS being infused throughout an organization. This requires both a bottom-up *and* a top-down approach to advancing and sustaining CLAS. Organizational governance and leadership are key to ensuring the successful adoption, implementation, and maintenance of CLAS. In recognition of this, the enhanced National CLAS Standards include a new Standard focused on the role of governance and leadership as it relates to CLAS. This new Standard was placed as the second Standard and within Theme 1, "Governance, Leadership, and Workforce."

The new second Standard states:

> Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

The inclusion of a Standard for organizational governance and leadership emphasizes the importance of a comprehensive effort to infuse culturally and linguistically appropriate services throughout an organization. The responsibility to embrace CLAS should fall throughout the entire organization. This comprehensive effort cannot succeed unless the governance and leadership of an organization has embraced these values and are willing to implement and sustain them. In addition, the scope of Standards 3 and 4 (Standards 2 and 3 in the original Standards) were expanded to include "governance and leadership" to continue to emphasize their integral role in the successful adoption of CLAS.

Looking Ahead: The Future and the National CLAS Standards

Since the inception of the original National CLAS Standards in 2000, the fields of cultural and linguistic competency have proven to be as dynamic as the diversity of our communities and the fields of health and health care themselves. Looking ahead, the ultimate goal is to ensure that the National CLAS Standards remain relevant until the next Enhancement Initiative. Following are some of the areas currently under consideration to achieve this goal.

Continued Enhancements

In recognition of this dynamic landscape, the HHS Office of Minority Health will revisit *The Blueprint* periodically to incorporate new and relevant resources as appropriate. Therefore, a Web version of *The Blueprint* will be maintained, which will reflect the more comprehensive and up-to-date resource.

In the event that a change in national policy occurs or research is published that impacts the integrity or validity of any of the Standards or content within the Standard chapters, appropriate revisions will be made and noted on the Office of Minority Health's Think Cultural Health website (www.thinkculturalhealth.hhs.gov).

State and Federal Legislation

State Legislation: Mandating Cultural and Linguistic Competency Training

In the years since the launch of the original National CLAS Standards, a number of states have implemented legislation pertaining to culturally and linguistically appropriate services (Graves, Like, Kelly, & Hohensee, 2007; HHS OMH Think Cultural Health, 2012). For many health professionals and organizations, the original National CLAS Standards served as a driver or model for what the legislation could include.

Federal Legislation: Affordable Care Act of 2010

The Affordable Care Act of 2010 lays an important foundation for advancing health equity and improving the quality of services to diverse communities (Andrulis, Siddiqui, Purtle, & Duchon, 2010; Youdelman, 2011). There are numerous provisions in the health care law related to cultural and linguistic competency, and the enhanced National CLAS Standards serve as a resource, at all levels, in these areas.

Support and Guidance

A recurring theme throughout the public comment portion of the Enhancement Initiative was the request for additional support and guidance in the implementation and maintenance of the National CLAS Standards. *The Blueprint* represents the first component of that support and guidance. While *The Blueprint* provides strategies for implementation, more targeted discipline- or profession-specific strategies may be necessary. It is anticipated that as part of the ongoing discussion of these efforts, collaborations will be formed with the aim of developing discipline specific support and guidance documents. Additional supporting documents will be made available on the Think Cultural Health website (www.thinkculturalhealth.hhs.gov).

Bibliography

Alliance of Community Health Plans. (2007). *Making the business case for culturally and linguistically appropriate services in health care: Case studies from the field*. Retrieved from the Office of Minority Health website: http://minorityhealth.hhs.gov/Assets/pdf/Checked/CLAS.pdf

Alegria, M., Lin, J., Chen, C., Duan, N., Cook, B., & Meng, X. (2012). The impact of insurance coverage in diminishing racial and ethnic disparities in behavioral health services. *Health Services Research, 47*(3), 1322-1344. doi:10.1111/j.1475-6773.2012.01403.x

Alvy, L.M., McKirnan, D.J., DuBois, S.N., Ritchie, N., Fingerhut, D., & Jones, K. (2011). Health care disparities and behavioral health among men who have sex with men. *Journal of Gay and Lesbian Social Services, 23*, 1-15.

American College of Physicians. (2010). *Racial and ethnic disparities in health care: Updated 2010*. Retrieved from http://www.acponline.org/advocacy/where_we_stand/access/racial_disparities.pdf

American Medical Association. (2006). *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations*. Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

Andrulis, D. P., Siddiqui, N. J., Purtle, J., & Duchon, L. (2010). *Patient Protection and Affordable Care Act of 2010: Advancing health equity for racially and ethnically diverse populations.* Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf

Association of American Medical Colleges. (1999). *Contemporary issues in medicine: Communication in medicine*. Retrieved from https://members.aamc.org/eweb/DynamicPage.aspx?Action=Add&ObjectKeyFrom=1A83491A-9853-4C87-86A4-F7D95601C2E2&WebCode=PubDetailAdd&DoNotSave=yes&ParentObject=CentralizedOrderEntry&ParentDataObject=Invoice%20Detail&ivd_formkey=69202792-63d7-4ba2-bf4e-a0da41270555&ivd_prc_prd_key=7A646605-335A-474C-99DD-5F1AD10D96BC

Au, M., Taylor, E., & Gold, M. (2009). *Improving access to language services in health care: A look at national and state efforts*. Retrieved from http://www.ahrq.gov/populations/languageservicesbr.pdf

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., ... Powe, N. R. (2004). *Strategies for improving minority healthcare quality*. (AHRQ Publication No. 04-E008-02). Retrieved from the Agency of Healthcare Research and Quality website: http://archive.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Betancourt, J.R. (2004). Cultural competence – marginal or mainstream movement? *New England Journal of Medicine, 351*, 953-955.

Betancourt, J.R. (2006). *Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care*. (Commonwealth Fund Publication No. 961). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Oct/Improving%20Quality%20and%20Achieving%20Equity%20%20The%20Role%20of%20Cultural%20Competence%20in%20Reducing%20Racial%20and%20Ethni/Betancourt_improvingqualityachievingequity_961%20pdf.pdf

Betancourt, J.R., Green, A.R., Carrillo, J.E., & Park, E.R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*, 499-505.

Brach, C., & Fraser, I. (2002). Reducing disparities through culturally competent health care: An analysis of the business case. *Quality Management in Health Care, 10*, 15-28.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*, 181-217.

Briefer French, J., Schiff, D., Han, E., & Weinick, R. (2008). *Multicultural health care: A quality improvement guide*. Retrieved from National Committee for Quality Assurance website: http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf

Buchmueller T., & Carpenter C.S. (2010). Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000–2007. *American Journal of Public Health. 100*(3), 489-495.

Chin, J.L. (2000). Culturally competent health care. *Public Health Reports, 115*, 25-33.

Cohen, E., & Goode, T.D. (1999), revised by Goode, T.D., & Dunne, C. (2003). *Policy brief 1: Rationale for cultural competence in primary care*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

DeCola, A. (2010). Making language access to health care meaningful. *Journal of Law and Health, 58*, 151- 182. Retrieved from http://www.imiaweb.org/uploads/docs/Making_Language_Access_to_Healthcare_Meaningful.pdf

DeLaet, D. E., Shea, S., & Carrasquillo, O. (2002). Receipt of preventive services among privately insured minorities in managed care versus fee-for-service insurance plans. *Journal of General Internal Medicine, 17,* 451–457. doi:10.1046/1525-1497.2002.10512.x

Diamond, L.C., Wilson-Stronks, A., & Jacobs, E.A. (2010). Do hospitals measure up to the National Culturally and Linguistically Appropriate Services Standards? *Medical Care, 48*, 1080-1087.

Exec. Order No. 13,166, 3 C.F.R. 289 (2000).

Frable, D. E. S. (1997). Gender, racial, ethnic, sexual, and class identities. *Annual Review of Psychology, 48,* 139–162. doi:10.1146/annurev.psych.48.1.139

Flores, G. (2006). Language barriers to health care in the United States. *New England Journal of Medicine, 355,* 229–231. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp058316

Geiger, H.J. (2001). Racial stereotyping and medicine: The need for cultural competence. *Canadian Medical Association Journal, 164*, 1699-1700.

Genao, I., Bussey-Jones, J., Brady, D., Branch, W.T., Corbie-Smith, G. (2003). Building the case for cultural competence. *American Journal of the Medical Sciences, 326*(3), 136-140.

Goode, T.D., & Dunne, C. (2003). *Policy brief 1: Rationale for cultural competence in primary care*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Gilbert, J., Goode, T. D., & Dunne, C. (2007). Cultural awareness. In *Curricula enhancement module series*. Retrieved from the National Center for Cultural Competence website: http://www.nccccurricula.info/awareness/index.html

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). *The evidence base for cultural and linguistic competency in health care*. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

Graves, D. (2001). *Your golden rule might not be mine and other lessons learned from cultural competency.* Workshop presented as part of Year One Orientation at the University of Missouri-Kansas City School of Medicine.

Graves, D. L., Like, R. C., Kelly, N., & Hohensee, A. (2007). Legislation as intervention: A survey of cultural competence policy in health care. *Journal of Health Care Law and Policy, 10*(2), 339–361. Retrieved from http://thecqc.org/uploads/Graves_et_al.pdf

Griffith, D. M., Yonas, M., Mason, M., & Havens, B. (2010). Considering organizational factors in addressing healthcare disparities: Two case examples. *Health Promotion Practice, 11*(3), 367–376. doi:10.1177/1524839908330863

Health Research & Educational Trust, Institute for Diversity in Health Management (2011). *Building a culturally competent organization: The quest for equity in health care*. Retrieved from http://www.hret.org/quality/projects/resources/cultural-competency.pdf

Hornberger J., Itakura H., & Wilson S.R. (1997). Bridging language and cultural barriers between physicians and patients. *Public Health Reports, 112*(5), 410-7.

Institute of Medicine. (2001). *Crossing the quality chasm: A new system of health for the 21st century*. Retrieved from http://www.nap.edu/openbook.php?isbn=0309072808

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1

Institute of Medicine. (2004). *In the Nation's compelling interest: Ensuring diversity in the health care workforce*. Washington, DC: The National Academies Press.

Johnson, R.L., Saha, S., Arbelaez, Beach, M.C., & Cooper, L.A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine, 19*, 101-110.

The Joint Commission. (2010). A*dvancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Kairys, J., & Like, R.C. (2006). Caring for diverse populations: Do academic family medicine practices have CLAS? *Family Medicine, 38*, 196-205.

Khanna, S. K., Cheyney, M., & Engle, M. (2009). Cultural competency in health care: Evaluating the outcomes of a cultural competency training among health care professionals. *Journal of the National Medical Association*, *101*, 886–892.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88*, 251-258.

Kumagai, A.K., & Lypson, M.L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*, 782-787.

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). *The economic burden of health inequalities in the United States*. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyel, S., & Braddock, C. H. (2010). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine*, *26*(3), 317–325. doi:10.1007/s11606-010-1529-0

McKirnan, D.J., DuBois, S.N., Alvy, L.M., & Jones, K. (2012). Health care access and health behaviors among men who have sex with men: The cost of health disparities. *Health Education and Behavior*. Advance online publication. doi:10.1177/1090198111436340

National Partnership for Action to End Health Disparities. (2011a). *National stakeholder strategy for achieving health equity*. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

National Partnership for Action to End Health Disparities. (2011b). *Toolkit for community action*. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://minorityhealth.hhs.gov/npa/files/Plans/Toolkit/NPA_Toolkit.pdf

Passel, J. S., & Cohn, D. (2008). *U.S. population projections: 2005-2050*. Retrieved from the Pew Research Center website: http://pewsocialtrends.org/files/2010/10/85.pdf

Ross, L. (1995). The spiritual dimension: Its importance to patients' health, well-being and quality of life and its implication for nursing practice. *International Journal of Nursing Studies, 32*(5), 457-468.

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence, and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2824588/?tool=pubmed

Sperling, J. (2011). *Communicating more for less: Using translation and interpretation technology to serve limited English proficient individuals*. Retrieved from the Migration Policy Institute website: http://www.migrationpolicy.org/pubs/LEP-translationtechnology.pdf

Sue, D.W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790-821.

Sullivan, L.W., & Mittman, I.S. (2010). The state of diversity in the health professions a century after Flexner. *Academic Medicine, 85*, 246-253.

The Patient Protection and Affordable Care Act, PL 111-148 (2010).

Thom, D., Hall, M., & Pawlson, G. (2004). Measuring patients' trust in physicians when assessing quality of care. *Health Affairs 23*(4), 124-132.

Thorson, J.A., & Cook, T.C. (1980). *Spiritual well-being of the elderly*. Springfield, IL: Charles C Thomas Publisher Ltd.

Tseng, W.S., & Streltzer, J.M. (2008). Culture and medical practice. In W.S., Tseng & J.M. Streltzer (eds.). *Cultural competence in health care*. (pp.1-12). New York: Springer.

U.S. Department of Commerce, Census Bureau. (2010). *American community survey*. Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02&prodType=table

U.S. Department of Health and Human Services. (2011). *HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care*. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012a). *National healthcare quality report*. (AHRQ Publication No. 12-0005). Retrieved from http://www.ahrq.gov/qual/measurix.htm#quality

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012b). *National healthcare disparities report*. (AHRQ Publication No. 12-0006). Retrieved from http://www.ahrq.gov/qual/measurix.htm#disparity

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2011). CDC Health disparities and inequalities report – United States, 2011. *MMWR, 60*, 1-109.

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2005). *Transforming the face of health professions through cultural and linguistic competence education: The role of the HRSA centers of excellence*. Retrieved from http://www.hrsa.gov/culturalcompetence/cultcompedu.pdf

U.S. Department of Health and Human Services, Indian Health Services. (n.d.). *Our mission*. Retrieved from http://www.ihs.gov/index.cfm?module=ihsIntro

U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons*. Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010a). *Healthy people 2020: Social determinants of health*. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010b). *Healthy people 2020*. Retrieved from http://www.healthypeople.gov/2020/default.aspx

U.S. Department of Health and Human Services, Office of Minority Health. (2005). *What is cultural competency?* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

U.S. Department of Health and Human Services, Office of Minority Health (2011). *National partnership for action to end health disparities*. Retrieved from http://minorityhealth.hhs.gov/npa

U.S. Department of Health and Human Services, Office of Minority Health, Think Cultural Health. (2012). *CLAS legislation map*. Retrieved from https://www.thinkculturalhealth.hhs.gov/Content/LegislatingCLAS.asp

U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 National strategy for suicide prevention: Goals and objectives for action*. Retrieved from http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

World Health Organization. (1946). *Definition of health in preamble to the constitution of the World Health Organization*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2012). *Social determinants of health*. Retrieved from http://www.who.int/social_determinants/en/

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation*. Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Youdelman, M. (2011). *The ACA and language access*. Retrieved from the National Health Law Program website: http://www.healthlaw.org/images/stories/Short_Paper_5_The_ACA_and_Language_Access.pdf

Youdelman, M., & Perkins, J. (2005). *Providing language services in small health care provider settings: Examples from the field* (Commonwealth Fund Publication No. 810). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf

Zambrana, R.E., Molnar, C., Munoz, H.B., & Lopez, D.S. (2004). Cultural competency as it intersects with racial/ethnic, linguistic, and class disparities in managed healthcare organizations. *American Journal of Managed Care, 10*, SP37-SP44.

The Blueprint

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS offers a user-friendly format for providing comprehensive — but by no means exhaustive — information on each Standard.

Each chapter is structured in the following manner:

Table 1: Blueprint Chapter Structure

Standard:	Statement of the National CLAS Standard
Purpose:	A list of many of the Standard's purposes to contextualize its intent and importance
Components of the Standard:	An explanation of the Standard's elements to provide additional information on the concepts presented
Strategies for Implementation:	Practical recommendations on implementing each Standard in various organizations or settings
Resources:	Seminal documents and other relevant resources related to the Standard to assist individuals and organizations in laying the foundation for CLAS
Bibliography:	Documents cited within the Standard chapter

The HHS Office of Minority Health will also maintain a Web version of *The Blueprint* to provide a more comprehensive and up-to-date resource. It is our hope that *The Blueprint* will aid in the adoption of the enhanced National CLAS Standards in order to help advance better health and health care in the United States.

Standard 1: Provide Effective, Equitable, Understandable, and Respectful Quality Care and Services

Standard 1

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Purpose

The purposes of providing effective, equitable, understandable, and respectful quality care and services are:

- To create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care
- To ensure that all individuals receiving health care and services experience culturally and linguistically appropriate encounters
- To meet communication needs so that individuals understand the health care and services they are receiving, can participate effectively in their own care, and make informed decisions
- To eliminate discrimination and disparities

Components of the Standard

Effective, equitable, understandable, and respectful quality care and services

Effective care and services are those that successfully restore an individual to his/her desired health status and help to protect his/her future

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

health. An essential part of ensuring that care and services are effective is to ensure that they are culturally and linguistically appropriate (IOM, 2003). All health care and services should be culturally and linguistically appropriate, including but not limited to health promotion, disease prevention, diagnosis, treatment, supportive care, rehabilitation, palliative end-of-life care, mental and behavioral health, emergency care, and wellness interventions. Vital to the provision of effective health care and services, providers must accurately understand the issue or illness, determine the course of treatment or services for that individual, and negotiate the solution or treatment successfully with the individual. Cultural and linguistic competency allows providers to navigate the cultural and linguistic factors that affect trust, rapport, communication, and adherence (Ngo-Metzger et al., 2006).

Equitable care and services must apply to all individuals and groups regardless of their cultural identity or identities. The aim of equitable care and services is to reduce the burden of illness, injury, and disability and to improve the health and functioning of all people in the United States (IOM, 2001). Equity is a key component of quality care (National Quality Forum, 2009). Equitable care and services are influenced by a number of factors, including but not limited to race, education, health literacy, age, sexual orientation, ethnicity, religion, physical or mental disability, language, gender, gender expression, gender identity, income, class, and access to care (California Pan-Ethnic Health Network, 2010; National Partnership for Action to End Health Disparities, 2011). The Joint Commission states in *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* that all individuals have the right to be free of discrimination while accessing care or services, whether or not that is included in the specific state's laws and regulations (The Joint Commission, 2010).

Understandable care and services rely on a clear exchange of information between those providing care and services and those receiving them. Individuals should be able to fully comprehend how to access care and services, what their treatment options are, and what they need to get and stay well. Ensuring that care and services are understandable is particularly important to those who have limited English proficiency, are deaf or hard of hearing, or may have difficulty comprehending the health care system and its terminology. It is estimated that nearly 90% of adults have difficulty using everyday health information routinely found in health care facilities, retail outlets, media, and communities. Such estimates highlight the significance of ensuring that health care and services are understandable since limited health literacy is associated with, among other factors,

poorer health outcomes and higher health care costs (HHS ODPHP, 2012). See also Health Literacy section of this chapter.

Respectful care and services are important to fostering an environment in which individuals from diverse backgrounds will feel comfortable discussing their needs with any member of an organization's staff. The HHS Consumer Bill of Rights states that all recipients of services have "the right to considerate, respectful care from all members of the health care system at all times and under all circumstances" (Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1997, Chapter 5, para. 1).

Accordingly, all members of the health and health care team should:

- Provide individuals with assurances that disrespect or discrimination of any kind is intolerable
- Provide individuals with reasonable assistance to overcome language, cultural, physical, or communication barriers

Cultural Health Beliefs and Practices

The integrated pattern of thoughts, communications, actions, beliefs, values, and institutions associated with one's cultural identity informs how individuals perceive illness, its cause, its treatment, and what wellness may look like (Horky et al., n.d.). Cultural beliefs and practices also influence how individuals cope with chronic or terminal illnesses. Health professionals should understand and be aware of the role that cultural health beliefs and practices play in their own lives as well as the lives of the individuals seeking services.

A commitment to lifelong learning is an intrinsic value to many in the fields of health and health care (Association of American Medical Colleges and American Association of the Colleges of Nursing, 2010; American Physical Therapy Association, 2012; American Public Health Association, n.d.). It is incumbent upon providers and staff members to include in their lifelong learning an ongoing commitment to self-reflection and honest self-assessment in order to understand how their own cultural beliefs inform their daily lives and professional activities (Tervalon & Murray-Garcia, 1998). It is through continued self-assessment and awareness of others' cultural beliefs that mutually beneficial relationships between provider and individual, and between organization and community, may be cultivated.

Providers and staff should inquire about and understand the healing practices and health regimens, including traditional healer services, used by the individuals they serve and integrate these approaches into treatment plans when appropriate. In the pursuit to learn about the various cultural beliefs and health practices in their communities, providers and staff should, whenever possible, gather this information directly from the individual seeking care or services. Through this awareness, the provider will be able to negotiate treatment options in a culturally and linguistically appropriate manner (American Institutes for Research, 2002). As providers and staff learn about the cultural health beliefs and practices of different communities, it is important that this knowledge not be used to stereotype or overgeneralize (Tervalon & Murray-Garcia, 1998).

Preferred Languages

In the United States, over 24 million people (8.7% of the population) speak English less than very well (U.S. Census Bureau, 2010) and should be considered limited English proficient for health and health care purposes, according to The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010). In addition, individuals who are conversant in English may not adequately comprehend the complexities of health and medical discussions in English. Health professionals should determine the communication and language assistance needed for individuals with limited English proficiency, including interpreters, translated materials, signage and wayfinding. Furthermore, communication should reflect an appropriate health literacy level. According to the Roadmap for Hospitals, it is also critical to remember that someone who speaks English may not be able to read it (The Joint Commission, 2010). See also Understandable Care and Services and Health Literacy sections of this chapter.

Health Literacy

Health literacy is the degree to which an individual has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (HHS ODPHP, 2000). The majority of American adults have limited ability to be active participants and decision-makers when it comes to their health and health care needs.

- Only 12% of adults have proficient health literacy, meaning nearly 9 out of 10 adults may lack the skills needed to manage their health and prevent disease (Kutner, Greenburg, Jun, & Paulsen, 2006).

- Adults with limited literacy skills are less likely to manage their chronic diseases and more likely to be hospitalized than adults with stronger literacy skills. This leads to poorer health outcomes and higher health care costs (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011).
- There is a mismatch between the communication needs of the public and the communication level of professionals in the fields of health and human services. The complexity of health information and the health care delivery system affect an individual's ability to understand and use health information. A better match between the health literacy level of the population served and the health literacy level of the information communicated results in improved communication, greater adherence to treatment, greater ability to engage in self-care, improved health status, and greater efficiency and cost savings to the health system as a whole (HHS ODPHP, 2010).

The HHS Agency for Healthcare Research and Quality has developed a toolkit that outlines health literacy universal precautions, defined as "actions that minimize risk for everyone when it is unclear which patients may be affected" by low health literacy. Universal precautions are necessary because health professionals cannot always identify individuals with low health literacy (AHRQ, 2010) (see Standard 8).

Communication Needs

Individuals frequently report that health professionals are not meeting their communication needs. Racial and ethnic minorities, individuals with limited English proficiency, and those with less education are more likely to have communication difficulties and to rate health care communication poorly (Wynia & Matiasek, 2006). Communication needs of some individuals may be easily recognized, while others may be more difficult to discern (Wynia & Matiasek, 2006). According to The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, organizations should provide communication and language assistance to include interpreters, translated materials, signage and wayfinding, augmentative and alternative communication resources, and auxiliary aids and services (The Joint Commission, 2010). See Standards 5, 6, 7, and 8 and the Glossary for additional information and guidance.

Strategies for Achievement of the Principal Standard

Standard 1 is the Principal Standard because, conceptually, the ultimate aim in adopting the remaining Standards is to achieve Standard 1. Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of culturally and

linguistically appropriate services that are necessary to achieve the Principal Standard. For this reason, Strategies for Implementation specific to Standard 1 are not listed here. If each of Standards 2 through 15 is implemented and maintained, organizations will be better positioned to achieve the desired goal of "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

Resources

American Medical Association. (2006). *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations.* Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

Health Research & Educational Trust, Institute for Diversity in Health Management (2011). *Building a culturally competent organization: The quest for equity in health care.* Retrieved from http://www.hret.org/quality/projects/resources/cultural-competency.pdf

National Patient Safety Foundation. (n.d.). *Ask me 3.* Retrieved from http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3

Pfizer. (2011). *Prevalence calculator.* Retrieved from http://www.pfizerhealthliteracy.com/physicians-providers/PrevalenceCalculator.aspx

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2824588

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Health literacy universal precautions toolkit* (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy.* Retrieved from http://www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf

Wynia, M., & Matiasek, J. (2006). *Promising practices for patient-centered communication with vulnerable populations: Examples from eight hospitals* (Commonwealth Fund Publication No. 947). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Aug/Promising%20Practices%20for%20Patient%20Centered%20Communication%20with%20Vulnerable%20Populations%20%20Examples%20from%20Ei/Wynia_promisingpracticespatientcentered_947%20pdf.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (1997). *Consumer bill of rights and responsibilities: Report to the president of the United States*. Retrieved from http://www.opm.gov/insure/archive/health/cbrr.htm

Association of American Medical Colleges and American Association of the Colleges of Nursing. (2010). *Lifelong learning in medicine and nursing: Final conference report*. Retrieved from https://www.aamc.org/download/121492/data/macyreport2010.pdf.pdf

American Institutes for Research. (2002). *Teaching cultural competence in health care: A review of current concepts, policies and practices*. Retrieved from Office of Minority Health website: http://minorityhealth.hhs.gov/assets/pdf/checked/1/em01garcia1.pdf

American Physical Therapy Association. (2012). *Professional development, lifelong learning, and continuing competence in physical therapy*. Retrieved from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Professional_Development/ProfessionalDev.pdf

American Public Health Association. (n.d.). *The education board*. Retrieved from http://www.apha.org/about/gov/edboard/

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine, 155*(2), 97–107.

California Pan-Ethnic Health Network. (2010). *Building quality & equitable health care systems*. (Conference report). Retrieved from http://www.cpehn.org/pdfs/Building%20Quality%20and%20Equitable%20Health%20Care%20Systems%2010-10.pdf

Horky, S., Tribby, R., Becker, C., Phipps, M. J., Saperstein, M., Johnston, J., & Polanco, B.-P. (n.d.). Core concepts in cultural competence: Health beliefs. In *Cross-cultural health care: Case studies*. Retrieved from http://support.mchtraining.net/national_ccce/case0/concepts.html#4

Institute of Medicine. (2001). *Crossing the quality chasm: A new system of health for the 21st century*. Retrieved from http://www.nap.edu/openbook.php?isbn=0309072808

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy* (NCES 2006–483). Washington, DC: National Center for Education Statistics.

National Partnership for Action to End Health Disparities. (2011). *National stakeholder strategy for achieving health equity: Development of the national stakeholder strategy.* Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf

National Quality Forum. (2009). *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Retrieved from http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

Ngo-Metzger, Q., Telfair, J., Sorkin, D. H., Weidmer, B., Weech-Maldonado, R., Hurtado, M., & Hays, R. D. (2006). *Cultural competency and quality of care: Obtaining the patient's perspective*. Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Ngo-Metzger_cultcompqualitycareobtainpatientperspect_963.pdf

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

U.S. Department of Commerce, Census Bureau. (2010). *American community survey.* Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02&prodType=table

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Health literacy universal precautions toolkit* (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2000). Health communication and health IT. In *Healthy people 2010.* Retrieved from http://www.healthypeople.gov/2010/hp2020/Objectives/TopicArea.aspx?id=25&TopicArea=Health+Communication+and+Health+IT

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy.* Retrieved from http://www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2012). *Health literacy.* Retrieved from http://www.health.gov/communication/literacy

Wynia, M., & Matiasek, J. (2006). *Promising practices for patient-centered communication with vulnerable populations: Examples from eight hospitals* (Commonwealth Fund Publication No. 947). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Aug/Promising%20Practices%20for%20Patient%20Centered%20Communication%20with%20Vulnerable%20Populations%20%20Examples%20from%20Ei/Wynia_promisingpracticespatientcentered_947%20pdf.pdf

Standard 2: Advance and Sustain Governance and Leadership that Promotes CLAS and Health Equity

Standard 2

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Purpose

The purposes of advancing and sustaining governance and leadership that promotes CLAS and health equity are:

- To ensure the provision of appropriate resources and accountability needed to support and sustain initiatives
- To model an appreciation and respect for diversity, inclusiveness, and all beliefs and practices
- To support a model of transparency and communication between the service setting and the populations that it serves

Components of the Standard

Advance and sustain organizational governance and leadership that promotes CLAS and health equity

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

Standard 2 is a new Standard that resulted from the National CLAS Standards Enhancement Initiative. Standard 2 has been added to underscore that CLAS must permeate every aspect of the organization, from the top down and from the bottom up. Cultural and linguistic competency has historically been a grassroots strategy. However, it is the organization's leadership that establishes the culture of the organization through its priorities, expectations, and the behavior that it models (Schyve &

The Governance Institute, 2009) and through designing service delivery processes and expectations (Rice, 2007).

Health and health care governance and leadership bodies should make their commitment to CLAS highly visible to both staff and individuals in their service area (Wilson-Stronks & Galvez, 2007). Leadership, in large part, determines whether the organization's culture will embody quality, safety, and CLAS (Schyve & The Governance Institute, 2009), so much so that diversity in leadership has been found to be the single most significant predictor of adoption and adherence to the National CLAS Standards (Weech-Maldonado, 2007). This may be because support from governance and leadership enables the allocation of resources and services necessary to effectively and efficiently meet individual or group communication, cultural, religious, spiritual, mobility, and other needs, according to The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010).

The Health Research and Educational Trust, an affiliate of the American Hospital Association, poses two key questions for organizational leadership in regard to prioritizing cultural competency (HRET, 2011):

1. Has your board set goals on improving organizational diversity, providing culturally competent care, and eliminating disparities in care as part of your strategic plan?
2. Is diversity awareness and cultural competency training mandatory for all senior leadership, management, staff, and volunteers?

These two questions are directly related to enhanced National CLAS Standards 8 and 3, respectively, and emphasize that the key strategy for embedding CLAS within an organization is engaging leadership. Indeed, research has shown leadership commitment as one of the most significant elements for integrating cultural and linguistic competency and moving CLAS from theory to action (HHS OMH, 2004; Weech-Maldonado, 2007; Wu & Martinez, 2006). A multi-stakeholder expert panel convened by the American Medical Association and Health Research and Educational Trust in 2006 called on all health care organizations to regularly assess "leadership involvement; mission, goals and strategies; policies and programs; budget allocations; and workforce values" as they relate to culturally and linguistically appropriate services (AMA, 2006, pp. 28–32). In one study, patients at hospitals and clinics that scored just 5 points higher (out of 100) on a domain measuring resource allocation and leadership engagement in addressing CLAS were more likely to report receiving high-quality care and more likely to report high levels of trust in the organization, compared to those who scored lower (Wynia et al., 2010). Furthermore,

the National Quality Forum identifies leadership as one of the seven primary domains for measuring and reporting cultural competency.

> "Leadership recognizes that healthcare providers, clinical and organizational leaders, the governance board, and the community share responsibility for and play an essential role in the development and implementation of cultural competency activities, in setting policy and strategy and in monitoring organization performance. Leadership must aspire to reflect the diversity of the community served." (National Quality Forum, 2009, p. iv)

Promote CLAS and health equity through policy, practices, and allocated resources

Organizational governance and leadership play a key role in promoting CLAS and health equity through policies, practices, and resource allocation. Institutionalizing cultural competency into organizations' central missions; collecting race, ethnicity, and primary language data; and increasing the diversity of the leadership, governance, and workforce within the organization represent methods that leaders should use to improve equity, quality, and efficacy of services (HRET, 2011). The following table illustrates how a few prominent health and health care organizations promote CLAS and health equity; namely, through policies and practices described in their mission, vision, and/or values statements. While certainly not exhaustive, the examples listed illustrate how several organizations have sought to address these topics.

Table 2: Examples of Promoting CLAS Through Policy and Practice

American Public Health Association:	**http://www.apha.org/about/gov/execboard/executiveboardvisionmission.htm**
Mission: Improve the health of the public and achieve equity in health status	
Johns Hopkins Medicine:	**http://www.hopkinsmedicine.org/about/mission.html**
Mission: The mission of Johns Hopkins Medicine is to improve the health of the community and the world by setting the standard of excellence in medical education, research, and clinical care. Diverse and inclusive, Johns Hopkins Medicine educates medical students, scientists, health care professionals, and the public; conducts biomedical research; and provides patient-centered medicine to prevent, diagnose, and treat human illness.	
Vision: Johns Hopkins Medicine provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides medical leadership to the world.	

Core Values:

Excellence and Discovery	Diversity and Inclusion
Leadership and Integrity	Respect and Collegiality

Harvard Medical School: http://hms.harvard.edu/hms/facts.asp

Mission: To create and nurture a diverse community of the best people committed to leadership in alleviating human suffering caused by disease.

Mayo Clinic: http://www.mayoclinic.org/about/missionvalues.html

Mission: To inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education, and research.

Values: These values, which guide Mayo Clinic's mission to this day, are an expression of the vision and intent of our founders, the original Mayo physicians, and the Sisters of Saint Francis.

- ***Respect:*** Treat everyone in our diverse community, including patients, their families, and colleagues, with dignity.
- ***Compassion:*** Provide the best care, treating patients and family members with sensitivity and empathy.
- ***Integrity:*** Adhere to the highest standards of professionalism, ethics, and personal responsibility, worthy of the trust our patients place in us.
- ***Healing:*** Inspire hope and nurture the well-being of the whole person, respecting physical, emotional, and spiritual needs.
- ***Teamwork:*** Value the contributions of all, blending the skills of individual staff members in unsurpassed collaboration.
- ***Excellence:*** Deliver the best outcomes and highest quality service through the dedicated effort of every team member.
- ***Innovation:*** Infuse and energize the organization, enhancing the lives of those we serve, through the creative ideas and unique talents of each employee.
- ***Stewardship:*** Sustain and reinvest in our mission and extended communities by wisely managing our human, natural, and material resources.

Society of Public Health Educators: http://www.sophe.org/mission.cfm

Values: The Society of Public Health Educators is committed to:

- Responding to the needs of its members
- Delivering quality products and services
- Demonstrating integrity, accountability and transparency
- Promoting teamwork and collaboration
- Embracing diversity
- Respecting organizational tradition while encouraging innovation

In addition, Johns Hopkins Medicine recently adopted a multiyear strategic plan, entitled Diversity & Inclusion 2020, which establishes key goals for patient care, community engagement and involvement, and workforce development. In implementing this strategic plan, the organization established an Office of Diversity and Cultural Competence and appointed an Associate Dean of Diversity and a diversity specialist, and to develop e-

learning courses on diversity and cultural competency issues in conjunction with the School of Public Health's Center for Health Disparities Solutions. The hospital has developed partnerships with the community to foster increased diversity and community engagement (Johns Hopkins Medicine, n.d.).

Strategies for Implementation

The following are possible implementation strategies for advancing and sustaining governance and leadership that promotes CLAS and health equity:

From the National Quality Forum (2009):

- Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
- Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.
- Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization and couple this with an actionable plan.
- Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the populations in the service area.
- Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
- Commit to cultural competency through system-wide approaches that are articulated through written policies, practices, procedures, and programs.
- Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

From The Joint Commission (Wilson-Stronks & Galvez, 2007):

- Provide for internal multidisciplinary dialogues about language and culture issues.
- Create financial incentives to promote, develop, and maintain accessibility to qualified health care interpreters.

Resources

American Medical Association. (2006). Content area 1. Understand your organization's commitment. In *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations* (pp. 28–32). Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

Betancourt, J., Green, A., & King, R. (2008). *Improving quality and achieving equity: A guide for hospital leaders*. Retrieved from Massachusetts General Hospital, The Disparities Solutions Center website: http://www2.massgeneral.org/disparitiessolutions/z_files/disparities%20leadership%20guide_final.pdf

Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, National Center for Cultural Competence. (2000). *A planner's guide: Infusing principles, content and themes related to cultural and linguistic competence into meetings and conferences.* Retrieved from http://gucchd.georgetown.edu/products/PlannersGuide.pdf

Institute for Diversity in Health Management. (2004). *Strategies for leadership: Does your hospital reflect the community it serves? Diversity and cultural proficiency assessment tool for leaders*. Retrieved from http://www.aha.org/content/00-10/diversitytool.pdf

Institute for Diversity in Health Management. (2008). *Institute Resource Center*. Retrieved from http://www.diversityconnection.org/diversityconnection/membership/Institute-Resource-Center.jsp?fll=S12

Liteman, M., Campbell, S., & Liteman, J. (2006). *Retreats that work: Everything you need to know about planning and leading great offsites*. San Francisco, CA: Pfeiffer.

Management Sciences for Health. (n.d.). *The provider's guide to quality & culture*. Retrieved from http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Powell, L., & Taylor, C. (2004). *Hospital governing board assessment: A self-help guide*. Boise, ID: Mountain States Group.

Schyve, P. M., & The Governance Institute. (2009). *Leadership in healthcare organizations: A guide to Joint Commission leadership standards*. Retrieved from http://www.jointcommission.org/assets/1/18/WP_Leadership_Standards.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

American Medical Association. (2006). Content area 1. Understand your organization's commitment. In *Improving communication, improving care: How health care*

organizations can ensure effective, patient-centered communication with people from diverse populations (pp. 28–32). Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

Health Research & Educational Trust, Institute for Diversity in Health Management (2011). *Building a culturally competent organization: The quest for equity in health care.* Retrieved from http://www.hret.org/quality/projects/resources/cultural-competency.pdf

Johns Hopkins Medicine. (n.d.). *Diversity & inclusion 2020.* Retrieved from http://www.hopkinsmedicine.org/bin/s/x/diversity_and_inclusion.pdf

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

National Quality Forum. (2009). *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Retrieved from http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

Rice, M. F. (2007). Promoting cultural competency in public administration and public service delivery: Utilizing self-assessment tools and performance measures. *Journal of Public Affairs Education, 13,* 41–57.

Schyve, P. M., & The Governance Institute. (2009). *Leadership in healthcare organizations: A guide to Joint Commission leadership standards.* Retrieved from http://www.jointcommission.org/assets/1/18/WP_Leadership_Standards.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2004). *CLAS in health care: Implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care at the Alameda Alliance for Health.* Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/CLAS_healthcare.pdf

Weech-Maldonado, R. (2007, June). *Moving towards culturally competent health systems: Organizational and market factors*. Presented at the AcademyHealth Disparities Interest Group Meeting, Orlando, FL. Retrieved from http://www.academyhealth.org/files/interestgroups/disparities/weech-maldonador.pdf

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Standard 3: Recruit, Promote, and Support a Diverse Governance, Leadership, and Workforce

Standard 3

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

Purpose

The purposes of recruiting, promoting, and supporting a diverse governance, leadership, and workforce are:

- To create an environment in which culturally diverse individuals feel welcomed and valued
- To promote trust and engagement with the communities and populations served
- To infuse multicultural perspectives into planning, design, and implementation of CLAS
- To ensure diverse viewpoints are represented in governance decisions
- To increase knowledge and experience related to culture and language among staff

Components of the Standard

Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

It is essential that organizations develop focused strategies to recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce. Evidence suggests that organizations with a more diverse and better-trained workforce provide higher-quality care and experience greater patient satisfaction scores (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004; IOM, 2003). For example, in one study, organizations scoring higher on a scale of

workforce diversity and training had better odds of patients reporting that they received high-quality care (Wynia et al., 2010).

Diversity should be present throughout every level of the organization, from front office personnel to the senior leadership. Organizations and their staff should understand that diversity in governance, leadership, and the workforce is about ensuring that individuals holding any organizational position possess the necessary skills and qualifications to perform required duties. In addition, it should be recognized that simply hiring and retaining a culturally diverse governance, leadership, and workforce is not, by itself, sufficient to achieving culturally and linguistically appropriate services; all members of the organization must be appropriately trained and versed in basic cultural competency skills (Rose, 2011; Whealin & Ruzek, 2008). Supporting cultural diversity via recruitment, retention, and promotion is but one method to ensure, among other things, that the opportunity for provider-patient concordance exists and that the organizational culture is informed from a variety of perspectives (Smedley & Mittman, 2011).

Governance, leadership, and workforce that are responsive to the population in the service area

The United States is rapidly becoming a more diverse nation. Since the 2000 U.S. Census, the percentage of individuals identifying as either Hispanic or Asian has increased substantially (U.S. Census Bureau, 2011). It is projected that by 2050 the U.S. demographic makeup will be 47% White, 29% Hispanic, 13% Black and 9% Asian (Passel & Cohn, 2008). This diversity, however, is not represented within many of the health professions. Evidence indicates that an increase in racial and ethnic diversity among health professionals is associated with increased access to care for racial and ethnic minority patients, greater patient choice, more patient satisfaction and patient engagement, improved communication, and improved educational experiences for health students (Cooper & Powe, 2004; IOM, 2004). Being responsive to the community is important at all levels of the organization, including in the provision of care and services, strategic planning, evaluation, and decision-making (Cooper & Powe, 2004).

Diversity among staff providing direct services in support, outreach, or clinical roles is important but not sufficient. Though there may be a lack of diversity within certain health professions, organizations should still strive to increase diversity throughout the entire hierarchy of an organization, including among senior management, chief executives, and boards of directors. This can promote strategic planning as well as policymaking and decision-making that are inclusive of the cultural and linguistic needs of all individuals

(HHS Health Resources and Services Administration, 2006). Governance, leadership, and a workforce that is representative of the diversity of the communities served are motivating forces to make the organization's services increasingly relevant and effective for its constituents (U.S. Department of Commerce, 1999).

Responsive care should also apply across various contractual relationships. Many health care organizations use networks or affiliated providers to deliver services to their constituents. It is important that staff diversity encompasses all individuals involved in health care delivery, whatever their contractual or subcontractual relationship with the organization.

Strategies for Implementation

The following are possible implementation strategies for the recruitment, promotion, and support of a diverse governance, leadership, and workforce:

Recruitment

- Advertise job opportunities in targeted foreign language and minority health professional associations' job boards, publications, and other media (e.g., social media networks, professional organizations' email Listservs, etc.), and post information in multiple languages (QSource, 2005).
- Develop relationships with local schools, training programs, and faith-based organizations to expand recruitment base (QSource, 2005).
- Recruit at minority health fairs (QSource, 2005).
- Collaborate with businesses, public school systems, and other stakeholders to build potential workforce capacities and recruit diverse staff. In particular, linkages between academic and service settings can help identify potential recruits already in the educational "pipeline" and provide them with additional academic support and resources necessary to meet job requirements (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004).
- Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters.

Promotion and Support

The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010) provides the following

implementation strategies for the promotion and support of a diverse governance, leadership, and workforce:

- Create a work environment that respects and accommodates the cultural diversity of the local workforce.
- Develop, maintain, and promote continuing education and career development opportunities so all staff members may progress within the organization.
- Cultivate relationships with organizations and institutions that offer health and human service career training to establish volunteer, work-study, and internship programs.

Other strategies for promoting and supporting a diverse governance, leadership, and workforce include (HHS OMH, 2001):

- Promote mentoring opportunities.
- Conduct regular, explicit assessments of hiring and retention data, current workforce demographics, promotion demographics, and community demographics.
- Monitor work assignments and hire sufficient personnel to ensure a manageable and appropriate workload for bilingual/bicultural staff members.
- Use nonclinical support staff in cultural broker positions only after providing sufficient training and recognition (e.g., compensation, job title, or description).
- Promote diverse staff members into administrative or managerial positions where their cultural and linguistic capabilities can make unique contributions to planning, policy, and decision-making.
- Foster an environment in which differences are respected and that is responsive to the challenges a culturally and linguistically diverse staff brings into the workplace.

Resources

American Medical Association, The Ethical Force Program. (2006). Content area 4. Develop workforce. In *Improving communication—improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations* (pp. 47–54). Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

American Medical Association. (2012). *C-CAT: Patient centered communication.* Retrieved from http://www.ama-assn.org\go\ccat

Institute for Diversity in Health Management. (2004). *Strategies for leadership: Does your hospital reflect the community it serves? Diversity and cultural proficiency assessment tool for leaders*. Retrieved from http://www.aha.org/content/00-10/diversitytool.pdf

Smedley, B. D., Stith-Butler, A., & Bristow, L. R. (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce*. Retrieved from http://www.nap.edu/openbook.php?record_id=10885&page=1

The Sullivan Commission on Diversity in the Healthcare Workforce. (2004). *Missing persons: Minorities in the health professions*. Retrieved from http://www.aacn.nche.edu/media-relations/SullivanReport.pdf

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Cooper, L. A., & Powe, N. R. (2004). *Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance*. Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/programs/minority/cooper_raceconcordance_753.pdf

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1

Institute of Medicine. (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce*. Retrieved from http://www.nap.edu/openbook.php?record_id=10885&page=1

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Passel, J. S., & Cohn, D. (2008). *U.S. population projections: 2005-2050*. Retrieved from the Pew Research Center website: http://pewsocialtrends.org/files/2010/10/85.pdf

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips*. Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

Rose, P. R. (2011). Understanding cultural nuances and barriers to cultural appreciation. In P. R. Rose (Ed.), *Cultural competency for health administration and public health* (pp. 41–56). Sudbury, MA: Jones & Bartlett Publishers.

Smedley, B. D., & Mittman, I. S. (2011). The diversity benefit: How does diversity among health professionals address public needs? In R. A. Williams (Ed.), *Healthcare disparities at the crossroads with healthcare reform* (pp. 167–193). New York, NY: Springer.

The Sullivan Commission on Diversity in the Healthcare Workforce. (2004). *Missing persons: Minorities in the health professions*. Retrieved from http://www.aacn.nche.edu/media-relations/SullivanReport.pdf

U.S. Department of Commerce, Census Bureau. (2011). *Overview of race and Hispanic origin: 2010.* Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

U.S. Department of Commerce, Vice President Al Gore's National Partnership for Reinventing Government Benchmarking Study. (1999). *Best practices in achieving workforce diversity*. Retrieved from http://govinfo.library.unt.edu/npr/library/workforce-diversity.pdf

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2006). *The rationale for diversity in the health professions: A review of the evidence.* Retrieved from http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Whealin, J. M., & Ruzek, J. (2008). Program evaluation for organizational cultural competence in mental health practices. *Professional Psychology: Research and Practice, 39,* 320–328.

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Standard 4: Educate and Train Governance, Leadership, and Workforce in CLAS

Standard 4

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Purpose

The purposes of educating and training governance, leadership, and workforce in CLAS are:

- To prepare and support a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations
- To increase the capacity of staff to provide services that are culturally and linguistically appropriate
- To assess the progress of staff in developing cultural, linguistic, and health literacy competency
- To foster an individual's right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and health care

Components of the Standard

Educate and train governance, leadership, and workforce in culturally and linguistically appropriate services

In order for CLAS to be fully implemented, education and training for professionals working in health and human services must be ongoing. Cultural and linguistic competency concepts — including effective communication and patient-, family-, and community-based practices — should be incorporated not only into

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

all formal educational curricula but also into new and existing staff training and curricula.

Ongoing education and staff training ensures that governance, leadership, and the workforce are equipped with adequate knowledge, tools, and skills to appropriately manage cross-cultural encounters with individuals (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Consistent integration of cultural and linguistic competency with existent educational and training curricula reinforces an organization's commitment to providing CLAS and may increase buy-in across the organization based on improving recognition of the role culture and language play in the provision of care and services, including their roles in service efficiency, effectiveness, satisfaction, and outcomes (Rose, 2011; Wu & Martinez, 2006).

While cultural and linguistic competency should permeate all education, training, policies, procedures, and daily operations, opportunities to learn and hone specific CLAS-related knowledge and skills should also be available. For example, health profession students should learn about culturally specific information regarding disease incidence and prevalence or the effect of current and historical events on certain groups' interactions with the health and health care system (Betancourt et al., 2003). In addition, training of governance, leadership, and workforce could include review of, and emphasis on, honing existing communication or other related skills necessary to work effectively in cross-cultural encounters. The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010) states that efforts should include all relevant policies, services, and programs that pertain to care and services.

Education and training should be based on sound educational principles (e.g., adult learning), including pre- and post-training assessments, and be conducted by appropriately qualified individuals. For training, a knowledge-based, skill-based, or attitude-based approach should be adopted, based upon the needs and weaknesses of the organization, with the goal of ensuring the success of the training (Rose, 2011). Specific topics for training should be based on the responsibilities of each member of the workforce, leadership, or governance. Some common topics that might be relevant include (but are not limited to):

- Exploration of one's own cultural background and the cultural backgrounds of the individuals and populations served (AMA, 2006)
- The importance of effective communication to health care outcomes (AMA, 2006)

- Elements of effective communication of staff with individuals or groups of different cultures and different languages, including how to work with interpreters and use available language services effectively
- Effects of differences between the cultures of staff and individuals on clinical and other workforce encounters
- Strategies and techniques for the identification and resolution of cross-cultural conflicts between staff and individuals or groups and a discussion of the organization's complaint/grievance procedures (see Standard 14)
- Effects of cultural differences among individuals and staff on access to care, service utilization, quality of care, health outcomes, and individuals' satisfaction, including the importance of socio-economic status, race, ethnicity, disability status, sexual orientation, gender identity and other factors
- Importance of learning about the care of, and services to, individuals with limited English proficiency, low health literacy, disabilities or special needs, and diverse religious and spiritual backgrounds
- Discussion regarding discrimination based on race, ethnicity, sex, national origin, socioeconomic status, disability status, religion, sexual orientation, gender identity
- Application of laws and provisions that pertain to the delivery of culturally and linguistically appropriate care and services, including the Affordable Care Act of 2010, Title VI of the Civil Rights Act of 1964, HHS' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (HHS OCR, 2003), Executive Order 13166, and state-level legislation (Graves et al., 2007)
- Strategies for collecting race, ethnicity, sex, language, and disability status data in a sensitive manner

Finally, there are important potential risks in training about culture, which should be recognized and addressed. First, training must avoid simplistic generalizations that can lead to stereotyping of individuals from different cultural groups (AMA, 2006). Instead, training should "emphasize sensitivity to variations within populations as well as among populations, including individual variations in beliefs, expectations and preferred modes of communication" and "training should help all members of the workforce develop the knowledge and skills needed to explore these variations during the course of care or service" (AMA, 2006, p53). Second, it is essential for training to be linked to a comprehensive organizational strategy around CLAS — to be clearly related to organization

mission, goals, and objectives. Thus, training must be accompanied by coordinated initiatives to support data collection, performance improvement, and accountability. Training without an organization-wide commitment to CLAS may dilute the training's long-term ability to cultivate individuals' commitment to CLAS if the training establishes performance expectations that are not then supported throughout the organization.

Strategies for Implementation

The following are possible implementation strategies for educating and training governance, leadership, and workforce on CLAS:

- Engage staff in dialogues about meeting the needs of diverse populations (Wilson-Stronks & Galvez, 2007).
- Provide ongoing in-service training on ways to meet the unique needs of the population, including regular in-services on how and when to access language services for individuals with limited English proficiency (Wilson-Stronks & Galvez, 2007).
- Take advantage of internal and external resources available to educate governance, leadership, and workforce on cultural beliefs they may encounter (Wilson-Stronks & Galvez, 2007).
- Allocate resources to train current staff in cultural competency or as medical interpreters if they speak a second language, have completed language assessments, and show an interest in interpretation (QSource, 2005).
- Incorporate cultural competency and CLAS into staff evaluations (QSource, 2005).
- Provide opportunities for CLAS training that include regular in-services, brown-bag lunch series, orientation materials for new staff, and annual update meetings (QSource, 2005).
- Encourage staff to volunteer in the community and to learn about community members and other cultures (QSource, 2005), and work with community leaders and cultural brokers to create opportunities for such interactions.
- Evaluate education and training (see Standard 10).
- Take advantage of live and Web-based health disparities and cultural competency continuing education programs for clinicians and practitioners (Like, 2011).

Resources

American Academy of Family Physicians. (2001). *Quality care for diverse populations videos* [Video series]. Available from http://www.aafp.org/online/en/home/clinical/publichealth/culturalprof/quality-care-diverse-populations.html

American Academy on Communication in Healthcare. (n.d.). *Skills based courses* [Course summaries]. Retrieved from http://www.aachonline.org/?page=SkillsBasedCourses

Cross Cultural Health Care Program. (n.d.). *Course information: Bridging the gap* [Online training course summary]. Retrieved from http://www.xculture.org/BTGclassdesc.php

Graves, D. L., Like, R. C., Kelly, N., & Hohensee, A. (2007). Legislation as intervention: A survey of cultural competence policy in health care. *Journal of Health Care Law and Policy, 10*(2), 339–361. Retrieved from http://thecqc.org/uploads/Graves_et_al.pdf

Institute for Healthcare Communication. (2012). *Training.* Retrieved from http://healthcarecomm.org/training

Exec. Order No. 13,166, 3 C.F.R. 289 (2000).

Ring, J., Nyquist, J., Mitchell, S., Flores, H., & Samaniego, L. (2008). *Curriculum for culturally responsive health care: The step-by-step guide for cultural competence training.* Oxford, UK: Radcliffe Publishing.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (n.d.). *Training and continuing education online: Health literacy for public health professionals (web-based)* [Online training course summary]. Retrieved from http://www2a.cdc.gov/tceonline/registration/detailpage.asp?res_id=2074

U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Unified health communication 101.* Retrieved from http://www.hrsa.gov/publichealth/healthliteracy/index.html

U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons.* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations.* Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *A physician's practical guide to culturally competent care.* Retrieved from https://cccm.thinkculturalhealth.hhs.gov/

U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *Cultural competency curriculum for disaster preparedness and crisis response.* Retrieved from https://cccdpcr.thinkculturalhealth.hhs.gov/

U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *Culturally competent nursing care: A cornerstone of caring.* Retrieved from https://ccnm.thinkculturalhealth.hhs.gov/

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

American Medical Association. (2006). *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations.* Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118,* 293–302. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Graves, D. L., Like, R. C., Kelly, N., & Hohensee, A. (2007). Legislation as intervention: A survey of cultural competence policy in health care. *Journal of Health Care Law and Policy, 10*(2), 339–361. Retrieved from http://thecqc.org/uploads/Graves_et_al.pdf

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Like, R. C. (2011). Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions, 31*(3), 196–206.

QSource, Underserved Quality Improvement Organization Support Center. (2005).*CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

Rose, P. R. (2011). Understanding cultural nuances and barriers to cultural appreciation. In P. R. Rose (Ed.), *Cultural competency for health administration and public health* (pp. 41–56). Sudbury, MA: Jones & Bartlett Publishers.

U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons.* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf

Standard 5: Offer Communication and Language Assistance

Standard 5

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Purpose

The purposes of offering communication and language assistance are:

- To ensure that individuals with limited English proficiency and/or other communication needs have equitable access to health services
- To help individuals understand their care and service options and participate in decisions regarding their health and health care
- To increase individuals' satisfaction and adherence to care and services
- To improve patient safety and reduce medical error related to miscommunication
- To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere

Components of the Standard

Offer Language Assistance

Language assistance services are mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf or hard of hearing. As noted in The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and*

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

Family-Centered Care: A Roadmap for Hospitals, these services can include in-person interpreters, bilingual staff, or remote interpreting systems such as telephone or video interpreting, as well the translation of written materials or signage, sign language, or braille materials (The Joint Commission, 2010). Language assistance services facilitate the effective and accurate exchange of information between an individual with language and communication needs and his/her provider. By facilitating conversations regarding prevention, symptoms, diagnosis, treatment, and other issues, language assistance improves the quality of services and patient safety.

Language assistance services may be required by law for organizations that receive federal funds. In 2000, the President signed Executive Order 13166, which requires all federal agencies, as well as all recipients of federal financial assistance, to take reasonable steps to ensure meaningful access for limited English proficient persons to the services and care provided by their agency or organization (Executive Order no. 13,166, 2000). This legal requirement stems from the national origin nondiscrimination provisions of Title VI of the Civil Rights Act of 1964 and its implementing regulations (Executive Order no. 13,166, 2000).

Interpretation and translation can be delivered through a variety of means, depending upon the setting and the services being delivered. The following table compares and contrasts the acts of interpreting and translating. As with all culturally and linguistically appropriate services, it is important to monitor the quality and utilization of services.

Table 3: Interpreting and Translating

	Interpreting	**Translating**
Why	Interpreting overcomes language barriers to make communication possible.	Translating allows individuals who cannot read a specific language to obtain access to written information in their native tongue.
What	Quality interpreting reflects cultural terms, expressions, and idioms that have bearing on the meaning of the content. Interpreting must capture any expressions or nuances in meaning to maintain the impact of the original message. Interpreting is an action that, once having taken place, is done.	Quality translating must reflect cultural terms, expressions, and idioms that have bearing on the meaning of the content. A translation must capture any expression or nuances in meaning to maintain the impact of the original message. A translation is a product that is permanent and can be shared, stored, reviewed, and revised as often as desired.
Who	Interpreters commonly work by themselves as part of a triad with the patient and provider. Interpreters must have an advanced level of proficiency in both	A translator usually works as a part of a translation team that consists of individuals with advanced levels of proficiency in both languages and with exceptional research skills

	Interpreting	Translating
	languages and must possess exceptional listening and memory skills for accuracy and completeness in verbal expression. Special language aptitude is required in both the language of medical terminology and in health care systems. Traditionally, interpreters prepare and conduct research prior to the encounter, using resources such as dictionaries and consultation with professionals in a specific field to complete their work.	to ensure accuracy in work. Translation teams include proofreaders and editors (and in some cases, desktop publishers, and project managers). Special language aptitude is required in both the language of medical terminology and in health care systems. Translation teams also rely on dictionaries, consultation with professionals in a specific field, and other resources to complete their work.
How	Interpreters work "in the moment" and are compelled by the mode of interpreting. Interpreters may consult dictionaries or utilize other resources, but the time between each exchange is only a matter of seconds or minutes. Interpreters work bidirectionally, going back and forth between two languages. The interpreter functions as a conduit, clarifier, cultural broker, and advocate. Interpreters must be able to perform each role appropriately throughout the encounter. Interpreters must be sensitive and considerate of both cultures. The goal is to have the listener understand the message as if it were heard directly from the original speaker. The National Council for Interpreting in Health Care has published a Code of Ethics and Standards of Practice for interpreters (National Council on Interpreting in Health Care, 2004, 2005).	Translators work on a different timeframe. They must read an entire text for comprehension before starting the translation, often consulting dictionaries and other resources for correct grammar and terminology. Most translators usually translate into their native language(s). Translation is a process that requires analysis, conversion, proofreading, and editing. Translators must be sensitive and considerate of both cultures. Localization is a specialized form of translation in which a completely adapted product (translation) takes into consideration differences in culture as well as language, whether that product is software, an Internet site, or a manufactured product. The goal is to produce a translation that appears to have been done originally in the target country. The American Translators Association has issued a Code of Ethics and Professional Practice for translators (American Translators Association, n.d.).
Where	Interpreting takes place at a specific time and place. Interpreters work in public (in a hospital or clinic, for example) or in private (in the case of telephonic and video interpreters who work either from a home office or in a call center). Interpreters must be present at a specific location; i.e., onsite at a hospital or clinic, or at a location that has dedicated resources for telephonic interpreting or video remote	Translation can take place at any place and any time — only the final product is required to be at a specific place and time. Translators work in any setting, from the offices of a large translation department to the privacy of their homes.

Interpreting	Translating
interpreting.	
(National Health Law Program, 2010, pp. 3–4)	

Individuals who have limited English proficiency and/or other communication needs

Limited English proficiency is a concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without language assistance with respect to a particular type of service, benefit, or encounter (HHS OCR, 2004). As discussed in Standard 1, individuals may have communication needs not related to a language barrier, such as those who are deaf or hard of hearing, visually impaired, or disabled or those with low health literacy.

The primary recipient of language assistance is often the individual receiving care or services; however, other individuals — such as family members or caregivers — may be involved in the provision of support or care to an individual. If family members or caregivers also have limited English proficiency and/or other communication needs, their linguistic needs should also be met to ensure the best outcomes for the individual receiving care. It is important to determine whether the individual's medical decision-maker, health care proxy, or advocate has limited English proficiency, since these individuals may serve as the primary decision-makers regarding the care received by minors, aging parents, and/or individuals with disabilities (National Health Law Program, 2010).

Timely access to all health care and services

While there is no single definition for "timely" that is universally applicable, the HHS Office for Civil Rights is available to provide guidance and assistance to those seeking to understand timeliness in access to services. For example, the Office for Civil Rights notes that language assistance should be provided at a time and place that avoids the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on, or delay in, important rights, benefits, or services to the limited English proficient person (HHS OCR, 2004).

Strategies for Implementation

The following are possible implementation strategies for offering communication and language assistance:

- Ensure that staff is fully aware of, and trained in, the use of language assistance services, policies, and procedures (see Standard 4) (HHS OMH, 2005).
- Develop processes for identifying the language(s) an individual speaks (e.g., language identification flash cards or "I speak" cards) and for adding this information to that person's health record (QSource, 2005).
- Use qualified and trained interpreters to facilitate communication (Wilson-Stronks & Galvez, 2007), including ensuring the quality of the language skills of self-reported bilingual staff who use their non-English language skills during patient encounters (Regenstein, Andres, & Wynia, in press).
- Establish contracts with interpreter services for in-person, over-the-phone, and video remote interpreting (HHS OMH, 2005).
- Use cultural brokers when an individual's cultural beliefs impact care communication (Wilson-Stronks & Galvez, 2007).
- Provide resources onsite to facilitate communication for individuals who experience impairment due to a changing medical condition or status (e.g., augmentative and alternative communication resources or auxiliary aids and services) as noted in *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (The Joint Commission, 2010).

Resources

American Medical Association. (2007). *Office guide to communicating with limited English proficient patients*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf

Andrulis, D. P., & Brach, C. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American Journal of Health Behavior, 31,* S122–S133. Retrieved from http://www.cpehn.org/pdfs/Integrating%20Literace%20Paper%20-%20Andrulis.pdf

California Academy of Family Physicians. (2005). *Addressing language access issues in your practice: A toolkit for physicians and their staff members.* Retrieved from http://www.calendow.org/uploadedFiles/language_access_issues.pdf

Chen, A. H., Youdelman, M. K., & Brooks, J. (2007). The legal framework for language access in healthcare settings: Title VI and beyond. *Journal of General Internal Medicine, 22*(Supplement 2), 362–367. doi:10.1007/s11606-007-0366-2

Divi, C., Koss, R. G., Schmaltz, S. P., & Loeb, J. M. (2007). Language proficiency and adverse events in US hospitals: A pilot study. *International Journal of Quality in Health Care, 19*(2), 60–67. doi:10.1093/intqhc/mzl069

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Limited English proficiency: A federal interagency website. (n.d.). Retrieved from http://www.lep.gov

Robert Wood Johnson Foundation. (2008). *Speaking together toolkit.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=29653

U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations.* Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

American Translators Association. (n.d.). *Code of ethics and professional practice.* Retrieved from http://www.atanet.org/membership/code_of_ethics_commentary.pdf

Exec. Order No. 13,166, 3 C.F.R. 289 (2000).

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

National Council on Interpreting in Health Care. (2004). *A national code of ethics for interpreters in health care.* Retrieved from http://www.oregon.gov/OHA/oei/intrprtr/docs/NCIHC_NCE.pdf

National Council on Interpreting in Health Care. (2005). *National standards of practice for interpreters in health care.* Retrieved from http://mchb.hrsa.gov/training/documents/pdf_library/National_Standards_of_Practice_for_Interpreters_in_Health_Care%20(12-05).pdf

National Health Law Program. (2010). *What's in a word? A guide to understanding interpreting and translation in health care.* Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

Regenstein, M., Andres, E., & Wynia, M. K., for the Commission to End Health Care Disparities. (in press). *Safer use of physicians' second language skills in caring for patients with limited English proficiency: A report of the Commission to End Health Care Disparities with recommendations for clinicians, organizations, and policymakers.* Chicago: IL: American Medical Association.

U.S. Department of Health and Human Services, Office for Civil Rights. (2004). *Limited English proficiency (LEP).* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html

U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations.* Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Standard 6: Inform Individuals of the Availability of Language Assistance

Standard 6

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Purpose

The purposes of informing individuals of the availability of language assistance are:

- To inform individuals with limited English proficiency, in their preferred language, that language services are readily available at no cost to them
- To facilitate access to language services
- To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere

Components of the Standard

Inform all individuals of the availability of language assistance services

The provision of language assistance services is critical to ensuring quality, safety, satisfaction, and improved outcomes, and informing individuals that such services are available helps ensure their use. Organizations should take the appropriate steps to notify individuals of the availability of language assistance services and that they are available free of cost. Individuals in need of communication and language assistance may not know such services are available to them upon request. Commonly reported barriers to services among individuals who are limited English proficient include the lack of availability of language services or the lack of awareness that such services exist (Barr & Wanat, 2005; Flores, 2006). Thus,

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

organizations should provide notification of the availability of language assistance services at various points of contact and by various means.

Language assistance services may be required by law for organizations that receive federal funds. In 2000, the President signed Executive Order 13166, which requires all federal agencies, as well as all recipients of federal financial assistance, to take reasonable steps to ensure meaningful access for limited English proficient persons to the services and care provided by their agency or organization (Executive Order no. 13,166, 2000). This legal requirement stems from the national origin nondiscrimination provisions of Title VI of the Civil Rights Act of 1964 and its implementing regulations (Executive Order no. 13,166, 2000).

Organizations should provide the notification in the individual's preferred language as determined by a language identification tool (e.g., "I speak" cards). Staff and providers speaking to individuals, whether in person or over the phone, should provide notification of the communication and language assistance available. Notifications should also be provided in print and multimedia materials that are easy to understand and translated into the languages commonly used by the populations in the service area (HHS OMH, 2005).

All members of the organization should be fully aware of the communication and language assistance services available, as well as all related organizational policies and procedures. To achieve this, all members of the organization should be trained in how to access communication and language assistance and work with language assistance personnel in order to support requests that come from individuals seeking health care and services (see Standard 4). Research conducted by the National Health Law Program identified staff training as essential to ensuring that available language services are appropriately utilized (Youdelman, Perkins, Brooks, & Reid, 2007), and another study demonstrated that more effective staff training is associated with significantly higher ratings on patient-reported quality of care and trust in the organization (Wynia et al., 2010). These trainings may be conducted in person onsite (as a part of existing training), or they may be a part of online training and information dissemination (Youdelman et al., 2007).

To ensure that the organization's methods of providing notice of language assistance to individuals with limited English proficiency are effective, the organization should monitor, evaluate, and update the solutions on an ongoing basis. It may be important to consider the following questions:

- What factors are enablers and barriers to notifying individuals about available language assistance?
- What aspects of the language assistance notification process should be supported, encouraged, and replicated?
- What aspects of the language assistance notification process should be revised, improved, or eliminated?
- What are the recommendations for improving language assistance notification?
- Which of the recommendations should take priority in terms of implementation?

Strategies for Implementation

The following are possible implementation strategies for informing individuals of the availability of language assistance:

The HHS Office of Minority Health's *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* (2005) identified the following strategies to effectively inform individuals of the availability of language assistance:

- Determine the content and language of notices
- Decide how to communicate or provide notice to individuals
- Decide where to provide notice to individuals about the availability of assistance

In determining the content and languages of the notices, organizations should consider the following:

- Notification should describe what communication and language assistance is available, in what languages the assistance is available, and to whom they are available. It should clearly state that communication and language assistance is provided by the organization free of charge to individuals (HHS OMH, 2005).
- Notification should be easy to understand at a low literacy level (HHS OMH, 2005).

In deciding how to communicate or provide notice to individuals about the availability of language services, organizations should consider the following:

- ***Signage, Materials, and Multimedia:*** Organizations should reflect the languages regularly encountered in the service area in their signs, materials, and multimedia resources (Berger, 2005; HHS OCR, 2003). For those who may not be literate,

information can be conveyed orally or through signage using symbols or pictures (HHS OMH, 2005; Kashiwagi, 2004).

- ***Cultural Mediation:*** Another method for promoting quality communication is through the development of a cultural mediation program. A cultural mediator can act as a liaison between the culture of the organization and the culture of the individual. An additional strategy for notifying individuals of language services through mediation is by developing a health promotion program (e.g., community health workers and promotores de salud) that includes bilingual staff who train community members to share health and resource information with other community members (HHS OMH, 2005; Youdelman & Perkins, 2005;).
- ***Community Outreach:*** Providing notification throughout the community is also important for reaching those who may be unaware of the organization or what services the organization may provide. In accordance with Standard 13, consider sending notification through local health departments, community-based organizations, faith-based organizations, schools, or any other stakeholders who would benefit from having information on health services (HHS OCR, 2003; HHS OMH, 2005).
- ***Initial Point of Contact:*** It is recommended that organizations standardize procedures for staff members who serve as the initial point of contact for individuals, whether that is by telephone or in person. It may be appropriate to provide staff with a script to ensure that they inform individuals of the availability of language assistance and to inquire whether they will need to utilize any of the available services. Multilingual phone trees and voice mail should also be used to inform individuals of the available language assistance services and how to access them (HHS OCR, 2003; HHS OMH, 2005).
- ***Non-English Media:*** Organizations should publicize availability of language assistance services in local foreign language media, such as ethnic radio, newspapers, and television (HHS OMH, 2005; Youdelman et al., 2007).

In deciding where to provide notice to individuals about the availability of language services, organizations should consider the following:

- Points of entry or intake, including:
  - *Registration desks*
  - *Front desks*
  - *Waiting rooms*

  - *Financial screening rooms, where individuals may need to discuss and resolve billing issues*
  - *Pharmacy reception, where individuals may pick up prescriptions*

  (HHS OMH, 2005; Kashiwagi, 2004;)

- Areas where clinical work is performed, such as triage and medical exam rooms (HHS OMH, 2005).

Resources

American Medical Association. (2007). *Office guide to communicating with limited English proficient patients*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf

Brach, C., Fraser, I., & Perez, K. (2005). Crossing the language chasm. *Health Affairs, 24*(2), 424–434. doi:10.1377/hlthaff.24.2.424

Chen, A. (2006). Doctoring across the language divide. *Health Affairs, 25*(3), 808–813. doi:10.1377/hlthaff.25.3.808

Limited English proficiency: A federal interagency website. (n.d.). Retrieved from http://www.lep.gov

Meyers, K., Tang, G., & Fernandez, A. (2009). Responding to the language challenge: Kaiser Permanente's approach. *The Permanente Journal, 13*(3), 77–83. Retrieved from http://www.thepermanentejournal.org/files/Summer2009/language_challenge.pdf

National Association of the Deaf. (2012). Retrieved from http://www.nad.org/

Robert Wood Johnson Foundation. (n.d.). *Shared decision-making when an interpreter is needed: A case study with Latino men at risk for prostate cancer* (Grant details). Retrieved from http://www.rwjf.org/grants/grant.jsp?id=63830

U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations*. Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Barr, D. A., & Wanat, S. F. (2005). Listening to patients: Cultural and linguistic barriers to health care access. *Family Medicine, 37,* 199–204. Retrieved from http://www.stfm.org/fmhub/fm2005/March/Donald199.pdf

Berger, C. (2005). *Universal symbols in health care workbook.* Retrieved from Hablamos Juntos website: http://www.hablamosjuntos.org/signage/PDF/Best%20Practices-FINALDec05.pdf

Exec. Order No. 13,166, 3 C.F.R. 289 (2000).

Flores, G. (2006). Language barriers to health care in the United States. *New England Journal of Medicine, 355,* 229–231. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp058316

Kashiwagi, S. (2004). *A functional manual for providing linguistically competent health care services as developed by a community health center.* Los Angeles, CA: Asian Pacific Health Care Venture, Inc.

U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons.* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations.* Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Youdelman, M., & Perkins, J. (2005). *Providing language services in small health care provider settings: Examples from the field* (Commonwealth Fund Publication No. 810). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf

Youdelman, M., Perkins, J., Brooks, J. D., & Reid, D. (2007). *Providing language services in state and local health-related benefits offices: Examples from the field* (Commonwealth Fund Publication No. 995). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2007/Jan/Providing%20Language%20Services%20in%20State%20and%20Local%20Health%20Related%20Benefits%20Offices%20%20Examples%20From%20the%20Fi/Youdelman_providinglanguagesvcsstatelocalbenefitsoffices_995%20pdf.pdf

Standard 7: Ensure the Competence of Individuals Providing Language Assistance

Standard 7

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Purpose

The purposes of ensuring the competence of individuals providing language assistance are:

- To provide accurate and effective communication between individuals and providers
- To reduce misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues due to reliance on staff or individuals that lack interpreter training
- To empower individuals to negotiate and advocate, on their own behalf, for important services via effective and accurate communication with health and health care staff
- To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere

Components of the Standard

Ensure the competence of individuals providing language assistance

Before one can be considered qualified to interpret, translate, or provide other communication assistance, he/she must be assessed to determine his/her competence. Language ability alone does not qualify an individual to provide language assistance. Leading

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

organizations in the field of language assistance, as reported by the National Health Law Program (2010), have identified the requisite skills and qualifications of interpreters as follows:

- Active listening skills
- Message conversion skills
- Clear and understandable speech delivery
- Familiarity with regionalisms and slang in both languages
- Ability to identify differences in meaning due to dialects or regionalisms to ensure effective and accurate message conversion
- Ability to communicate in all registers and at varying levels of formality
- Understanding of colloquialisms and idiomatic expressions in all working languages
- Working knowledge of anatomy and physiology
- Extensive knowledge of the vocabulary and terminology related to diagnosis, prevention, treatment, and management of illness and disease
- Understanding of key concepts in health care, such as confidentiality, informed consent, and patients' rights
- Command of the vocabulary related to the provision of health care in both languages

A similar list of requisite skills and qualifications has also been compiled by the National Health Law Program (2010) for translators and is as follows:

- Intimate knowledge of their own native language
- Ability to write in the idiomatic and natural patterns of their native language
- Knowledge of the variety of fields in the health care system and of medical terminology; a basic knowledge of diseases, procedures, and medications; and knowledge of how the health care system, as a whole, functions
- Knowledge of their professional limits — especially, before agreeing to translate a document, being confident that they are qualified to translate it and can make an accurate assessment of the time it will take to complete the translation
- Good research skills and access to appropriate reference materials
- Expertise in various forms of written communication, from handwritten notes to digital

- Ability to translate medicolegal documents, such as informed consent forms and provisions of the Health Insurance Portability and Accountability Act
- Regular reading of professional literature in health care fields to maintain currency of information
- Continuous honing of translation skills through professional development courses or training

Use of untrained individuals and/or minors as interpreters should be avoided

Using ad hoc interpreters or untrained individuals and/or minors as interpreters may appear to be a convenient or reasonable option for the individual and provider alike. For service providers, using an ad hoc interpreter may appear to be advantageous because there may be little or no upfront financial cost associated with using untrained individuals and/or minors, and there may be little to no interruption in service delivery, since the untrained individual is likely readily available. However, the use of unqualified interpreters can have dire consequences. Grave errors have occurred when untrained individuals have been used as interpreters, including misdiagnoses and significant medical errors (Flores, 2005; Flores et al., 2003), which may place the individual at increased risk of significant injury or death. In one notable case, a first responder misinterpreted a single Spanish word, "intoxicado," to mean "intoxicated" rather than its intended meaning of "feeling sick to the stomach." This led to a delay in diagnosis, which resulted in a potentially preventable case of quadriplegia, and ultimately, a significant malpractice settlement (Flores, 2006).

Untrained family, friends, minors, and staff often do not possess the necessary skills to provide meaningful language services. Moreover, given their relationship to the patient, the use of friends, family members, and minors may compromise the autonomy and confidentiality of the communication (AMA, 2006; Diamond & Jacobs, 2010). There are numerous benefits to the utilization of trained interpreters. For example, research conducted in an emergency department found that the use of trained interpreters resulted in reduced return rates to the emergency department, increased clinic utilization, and lower 30-day discharges, with no concurrent increase in length of stay or cost of visit (Bernstein et al., 2002).

The primary role of the interpreter is to act as the conduit of information between the provider and the recipient of care or services. Family and friends should be present as a

means of support and shared decision-making if the individual so chooses. However, a loved one should not assume the additional burden and risk of interpretation errors. Children, especially minor children, may not have the cognitive or emotional maturity to function in the role of interpreter (Wilson-Stronks & Galvez, 2007). In addition, the use of children as interpreters has been found not only to place unnecessary tension in the parent-child relationship but also to place stress and emotional strain on the child (Flores, 2005, 2006; Jacobs, Kroll, Green, & David, 1995; Schenker, Lo, Ettinger, & Fernandez, 2008). Parents or caregivers may not want to share sensitive information with their children, and, therefore, health professionals may not be able to gather an accurate history. It can also be quite distressing for a friend, family member, or child to have to deliver poor prognostic information to the individual.

The use of clinical and nonclinical staff who speak a non-English language but who are untrained in medical interpretation can pose potential safety risks (Regenstein et al., in press). Research has shown that when clinicians speak a non-English language, or when untrained bilingual staff is available, an important set of potential barriers can arise and hinder the effective and appropriate use of trained interpreters (Maul, Regenstein, Andres, Wright, & Wynia, 2012).

Strategies for Implementation

Depending upon an organization's size, scope, and mission, its language assistance strategies will differ. Organizations may opt to provide interpretation services through in-person interpreters and bilingual staff and providers or through technological or electronic means, including telephonic or video remote interpreting. Translation may be conducted primarily internally or may be contracted to external organizations.

The following are possible implementation strategies for ensuring the competence of individuals providing language assistance:

- Assess the individual's language ability. There exist many options for testing an individual's ability to communicate in a foreign language. The following table summarizes two of the leading language proficiency scales, the American Council on the Teaching of Foreign Languages scale (ACTFL) and the Interagency Language Roundtable (ILR) scale (LinguaLinks Library, 1999):

ILR Scale	ACTFL Scale	Definition
5	Native	Able to speak like an educated native speaker
4+ 4	Distinguished	Able to speak with a great deal of fluency, grammatical accuracy, precision of vocabulary and idiomaticity
3+ 3	Superior	Able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations
2+	Advanced Plus	Able to satisfy most work requirements and show some ability to communicate on concrete topics
2	Advanced	Able to satisfy routine social demands and limited work requirements
1+	Intermediate - High	Able to satisfy most survival needs and limited social demands
1	Intermediate - Mid Intermediate - Low	Able to satisfy some survival needs and some limited social demands Able to satisfy basic survival needs and minimum courtesy requirements
0+	Novice – High	Able to satisfy immediate needs with learned utterances
0	Novice - Mid Novice - Low 0	Able to operate in only a very limited capacity Unable to function in the spoken language No ability whatsoever in the language

- Assess the individual's ability to provide language assistance. The American Translators Association upholds standards of practice for translation services (n.d.). Similarly, the National Council on Interpreting in Health Care has issued standards of practice that define expectations of performance and outcomes for health care interpreters (2005). In addition, the Certification Commission for Healthcare Interpreters and the National Board for Certification of Medical Interpreters provide national certification for interpreters.

  The standards of practice identified by these professional organizations may offer promising practices in the provision of linguistically appropriate services. Keeping these standards at the core of hiring, training, and evaluating individuals will help ensure their competence in providing language assistance.

- Employ a "multifaceted model" of language assistance. Organizations may provide language assistance according to a variety of models, including bilingual staff or dedicated language assistance (e.g., a contract interpreter or video remote interpreting). A combination of models, or a multifaceted model, offers the

organization a "comprehensive and flexible system [for] facilitating communication" (National Council on Interpreting in Health Care, 2002, p. 4). Under a multifaceted model, for example, telephonic interpreting will supplement the language assistance provided by bilingual staff to ensure that at all times, language assistance is being provided by competent individuals.

Resources

California Healthcare Interpreting Association. (n.d.). Retrieved from http://chiaonline.org/

Certification Commission for Healthcare Interpreters. (n.d.). Retrieved from http://www.healthcareinterpretercertification.org/

Commonwealth of Massachusetts Executive Office of Health and Human Services, Massachusetts Department of Public Health. (2004). *Best practice recommendations for hospital-based interpreter services*. Retrieved from http://www.hablamosjuntos.org/pdf_files/Best_Practice_Recommendations_Feb2004.pdf

Hablamos Juntos. (2008). *Language testing options 2008*. Retrieved from http://www.imiaweb.org/uploads/pages/218.pdf

International Medical Interpreters Association. (1995). *Medical interpreting standards of practice*. Retrieved from http://www.hablamosjuntos.org/resources/pdf/IMIA_Standards_Of_Practice.pdf

Limited English proficiency: A federal interagency website. (n.d.). Retrieved from http://www.lep.gov

National Board of Certification for Medical Interpreters. (2012). Retrieved from http://www.certifiedmedicalinterpreters.org/

National Council on Interpreting in Health Care. (2001). *Guide to initial assessment of interpreter qualifications.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20Guide%20to%20Initial%20Assessment%20of%20Interpreter%20Qualifications.pdf

Registry of Interpreters for the Deaf. (2012). *Standard practice papers*. Retrieved from http://www.rid.org/interpreting/Standard%20Practice%20Papers/index.cfm

Robert Wood Johnson Foundation. (2008). *Kaiser Permanente's health care interpreter certificate program.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=34036

Robert Wood Johnson Foundation. (2008). *Kaiser Permanente's qualified bilingual staff model.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=34030

Trott, J., West, C., Shah, P., & Regenstein, M. (2008). *Building a high-quality language services program toolkit*. Retrieved from

http://www.lawhelp.org/documents/391611Building%20a%20High-Quality%20Language%20Services%20Program%20Toolkit.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

American Medical Association. (2006). *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations.* Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

American Translators Association. (n.d.). *Code of ethics and professional practice.* Retrieved from http://www.atanet.org/membership/code_of_ethics_commentary.pdf

Bernstein, J., Bernstein, E., Dave, A., Hardt, E., James, T., Linden, J., Mitchell, P., Oishi, T., & Safi, C. (2002). Trained medical interpreters in the emergency department: effects on services, subsequent charges, and follow-up. *Journal of Immigrant Health, 4(4),* 171-176.

Diamond, L. C., & Jacobs, E. A. (2010). Let's not contribute to disparities: The best methods for teaching clinicians how to overcome language barriers to health care. *Journal of General Internal Medicine, 25*(Supplement 2), S189–S193. Retrieved from http://www.springerlink.com/content/00h67538730pl426/fulltext.pdf

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review, 62,* 255–299.

Flores, G. (2006). *Cases from AHRQ WebM&M: Language barriers are more than an inconvenience. Patient errors range from simple miscommunication to life-threatening.* Retrieved from http://www.medscape.com/viewarticle/534045

Flores, G. (2006). Language barriers to health care in the United States. *New England Journal of Medicine, 355,* 229–231. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMp058316

Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics, 111,* 6–14.

Jacobs, B., Kroll, L., Green, J., & David, T. J. (1995). The hazards of using a child as an interpreter. *Journal of the Royal Society of Medicine, 88,* 474P–475P. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1295307/pdf/jrsocmed00067-0056.pdf

LinguaLinks Library. (1999). *Correspondence of proficiency scales*. Retrieved from http://www.sil.org/lingualinks/LANGUAGELEARNING/MangngYrLnggLrnngPrgrm/CorrespondenceOfProficiencySca.htm

Maul, L., Regenstein, M., Andres, E., Wright, R., & Wynia, M. K. (2012). Using a risk assessment approach to determine which factors influence whether partially bilingual physicians rely on their non-English language skills or call an interpreter? *The Joint Commission Journal on Quality and Patient Safety*, *38* (7), 328-336.

National Council on Interpreting in Health Care. (2002). *Models for the provision of language access in health care settings*. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Models%20for%20Provision%20of%20Language%20Access.pdf

National Council on Interpreting in Health Care. (2005). *National standards of practice for interpreters in health care*. Retrieved from http://mchb.hrsa.gov/training/documents/pdf_library/National_Standards_of_Practice_for_Interpreters_in_Health_Care%20(12-05).pdf

National Health Law Program. (2010). *What's in a word? A guide to understanding interpreting and translation in health care*. Retrieved from http://www.healthlaw.org/images/stories/Whats_in_a_Word_Guide.pdf

Regenstein, M., Andres, E., & Wynia, M. K., for the Commission to End Health Care Disparities. (in press). *Safer use of physicians' second language skills in caring for patients with limited English proficiency: A report of the Commission to End Health Care Disparities with recommendations for clinicians, organizations, and policymakers*. Chicago, IL: American Medical Association.

Schenker, Y., Lo, B., Ettinger, K. M., & Fernandez, A. (2008). Navigating language barriers under difficult circumstances. *Annals of Internal Medicine, 149,* 264–269.

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation*. Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Standard 8: Provide Easy-to-Understand Materials and Signage

Standard 8

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Purpose

The purposes of providing easy-to-understand materials and signage are:

- To ensure that readers of other languages and individuals with various health literacy levels are able to access care and services
- To provide access to health-related information and facilitate comprehension of, and adherence to, instructions and health plan requirements
- To enable all individuals to make informed decisions regarding their health and their care and services options
- To offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members
- To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere

Components of the Standard

Provide easy-to-understand print and multimedia materials and signage

Print and multimedia materials offer an effective way of communicating with large numbers of people, supplementing information provided by clinicians, service providers, and other staff, and reinforcing key

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

messages from a health care or service encounter. Therefore, ensuring that an individual can read, comprehend, and act upon written materials is essential.

Unfortunately, many health materials are written at a level too high for the average consumer to understand (Rudd, Moeykens, & Colton, 2000). The challenge to understand health materials is even greater for the one-third of adults with limited health literacy (HHS ODPHP, 2010). Minority populations are disproportionately represented among those with basic or below basic health literacy skills (Kutner et al., 2006), and the failure to address health literacy may exacerbate disparities (Koh et al., 2012). Health literate organizations design and distribute print, audiovisual, and social media content that is easy to understand and act on (Brach et al., 2012). Such materials use appropriate graphics, employ user-friendly design, focus on actionable information, and refrain from using jargon. Processes should be established to develop and select materials appropriate for the population served. The National Action Plan to Improve Health Literacy lays out strategies for developing and disseminating health and safety information that is accurate, accessible, and actionable (HHS ODPHP, 2010). Health materials should be used effectively as part of an educational strategy rather than becoming a substitute for spoken instruction (AHRQ, 2010). Similarly, clear signage does not obviate the need for other navigational assistance.

It is also important to translate materials that are essential to individuals' accessing and making educated decisions about health care, including materials on the internet. Examples of relevant materials include:

- ***Administrative and legal documents*** — materials requiring informed consent, obligation, or acknowledgment of certain legal or financial rights and responsibilities; waivers of rights; living wills and advance directives; emergency room release and discharge forms; marketing materials; documents establishing and maintaining eligibility for services; explanations of benefit coverage packages; evidence of coverage cards; and notices of noncoverage
- ***Clinical information*** — prevention and treatment instructions, including how to prevent transmission of a communicable disease; what to do before, during, and after a procedure or treatment (e.g., surgery, chemotherapy); how to take medicine; and how to perform routine self-care or self-monitoring
- ***Education, health prevention and promotion, and outreach materials*** — brochures, fact sheets, pamphlets, promotional flyers and posters, health advisories, and other materials that support treatment programs (e.g., for chronic disease or

mental health) and prevention activities (e.g., cancer or high blood pressure screenings)

Multilingual signage in the languages of the populations in the service area should provide notices of rights, the availability of conflict and grievance resolution processes, and directions to facility services. In addition, wayfinding signage should identify or label the location of specific services.

Languages commonly used by the populations in the service area

Easy-to-understand print and multimedia materials and signage should be provided in the languages commonly used by populations in the service area. The HHS Office for Civil Rights offers guidance for organizations that receive federal funds to identify the language assistance services that need to be provided. This guidance will help health and health care organizations determine which documents and languages are to be addressed. The HHS Office for Civil Rights' individualized assessment strategy balances four factors (HHS OCR, 2003):

1. The number or proportion of limited English proficient persons eligible to be served or likely to be encountered by the program or grantee

2. The frequency with which individuals with limited English proficiency come into contact with the program

3. The nature and importance of the program, activity, or service provided by the recipient to its beneficiaries

4. The resources available to the grantee/recipient and the costs of interpretation/translation services. There is no one-size-fits-all solution for Title VI compliance with respect to limited English proficient persons, and what constitute reasonable steps for large providers may not be reasonable where small providers are concerned.

According to guidance from the HHS Office for Civil Rights, organizations that receive federal funds may be required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons. What constitutes meaningful access is made on a case-by-case basis, and therefore all organizations should determine their level of responsibility by conducting the four-factor analysis outlined above and developing a language assistance plan (HHS OCR, 2003).

Strategies for Implementation

The following are possible implementation strategies for providing easy-to-understand materials and signage:

- Issue plain language guidance and create documents that demonstrate best practices in clear communication and information design (HHS ODPHP, 2010).
- Create forms that are easy to fill out, and offer assistance in completing forms (AHRQ, 2010).
- Consult local librarians to help build an appropriate collection of health materials (HHS ODPHP, 2010).
- Train staff to develop and identify easy-to-understand materials, and establish processes for periodically re-evaluating and updating materials (AHRQ, 2010).
- Formalize processes for translating materials into languages other than English and for evaluating the quality of these translations (Wilson-Stronks & Galvez, 2007).
- Develop materials in alternative formats for individuals with communication needs, including those with sensory, developmental, and/or cognitive impairments as noted in *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (The Joint Commission, 2010).
- Test materials with target audiences. For example, focus group discussions with members of the target population can identify content in the material that might be embarrassing or offensive, suggest cultural practices that provide more appropriate examples, and assess whether graphics reflect the diversity of the target community. Organizations should consider providing financial compensation or in-kind services to community members who help translate and review materials (HHS OMH, 2001).

Resources

Centers for Medicare & Medicaid Services. (2011). *The toolkit for making written material clear and effective: Overview.* Retrieved from https://www.cms.gov/WrittenMaterialsToolkit/

Downing, B., & Bogoslaw, L. (2003). *Translation as a strategy for effective communication with patients and clients: A how-to guide.* Retrieved from Hablamos Juntos website: http://www.hablamosjuntos.org/pdf_files/BruceDowningHow-To_Guide_FINAL.pdf

Harvard School of Public Health. (2010). *Health literacy studies: Assessing and developing health materials.* Retrieved from http://www.hsph.harvard.edu/healthliteracy/practice/innovative-actions/index.html

Health Literacy Innovations. (2008). *The health literacy & plain language resource guide.* Retrieved from http://www.healthliteracyinnovations.com/information/RGdownload

Limited English proficiency: A federal interagency website. (n.d.). Retrieved from http://www.lep.gov

National Council on Interpreting in Health Care. (2010). *Sight translation and written translation: Guidelines for healthcare interpreters.* Retrieved from http://data.memberclicks.com/site/ncihc/Translation%20Guidelines%20for%20Interpreters%20REVISED%2031710.pdf

National Health Law Program. (2010). *What's in a word? A guide to understanding interpreting and translation in health care.* Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf

Osborne, H. (2001, November). *In other words...Can they understand? Testing patient education materials with intended readers.* Retrieved from http://www.healthliteracy.com/article.asp?PageID=3811 (Reprinted from the *Boston Globe On Call* magazine)

Pierce, L. (2010). How to choose and develop written educational materials. *Rehabilitation Nursing, 35*(3), 99–105. Retrieved from http://www.rehabnurse.org/pdf/rnj320.pdf

Plain Language Association International. (2011). Retrieved from http://www.plainlanguagenetwork.org/

Txabarriaga, R. (2009). *IMIA guide on medical translation.* Retrieved from International Medical Interpreters Association website: http://www.imiaweb.org/uploads/pages/438.pdf

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Health literacy universal precautions toolkit* (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

American Medical Association. (2006). *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations.* Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

Brach, C., Dreyer, D., Schyve, P., Hernandez, L. M., Baur, C., Lemerise, A. J., & Parker, R. (2012). *Attributes of a health literate organization.* Retrieved from: http://www.iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_HLit_Attributes.pdf

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Koh, H. K., Berwick, D. M., Clancy, C. M., Baur, C., Brach, C., Harris, L. M., & Zerhusen, E. G. (2012). New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly 'crisis care'. *Health Affairs, 31*(2), 434–443.

Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). *The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy* (NCES 2006–483). Washington, DC: National Center for Education Statistics.

Rudd, R., Moeykens, B. A., & Colton, T. C. (2000). Health and literacy: A review of the medical and public health literature. In J. Comings, B. Gerners, & C. Smith (Eds.), *Annual review of adult learning and literacy* (pp. 175-203). New York: Jossey-Bass.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Health literacy universal precautions toolkit* (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/

U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons.* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy.* Retrieved from http://www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Standard 9: Infuse CLAS Goals, Policies, and Management Accountability Throughout the Organization's Planning and Operations

Standard 9

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Purpose

The purposes of infusing CLAS throughout the organization's planning and operations are:

- To make CLAS central to the organization's service, administrative, and supportive functions
- To integrate CLAS throughout the organization (including the mission) and highlight its importance through specific goals
- To link CLAS to other organizational activities, including policy, procedures, and decision-making related to outcomes accountability

Components of the Standard

Establish culturally and linguistically appropriate goals, policies, and management accountability

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

Establishing goals, policies, and management accountability that promote CLAS throughout an organization helps to ensure that an organization is culturally and linguistically competent at every point of contact and ties CLAS to organizational priorities such as individuals' experiences, satisfaction, safety, and outcomes. This also illustrates the relevance of CLAS even in times of budgetary constraints and limited resources (Wu & Martinez, 2006). In addition, this integrated

approach demonstrates to the community that cultural and linguistic competency is integral to the organization's mission and vision.

Infuse CLAS throughout the organization's planning and operations

Culturally and linguistically appropriate services should be embedded throughout all levels of the organization—from the top down and from the bottom up. The entire health or health care organization affects quality of services and health outcomes of individuals; therefore, the entire organization should fully integrate CLAS- and health equity–related concepts and ideals. Different departments, policies, and roles should coordinate with and complement each other to this end.

Health and health care organizations should incorporate CLAS goals, policies, and accountability procedures at all levels by making them key aspects of the organization's planning and operations (Weech-Maldonado, 2002). Organizations are encouraged to embed CLAS as a core element of the organization's identity, mission, operating principles, service focus, budget, and quality improvement activities (AMA, 2006). For example, a health organization might collect and merge individual-level demographic data and quality improvement measures together to illustrate equitable health care as a quality improvement goal (Wilson-Stronks & Galvez, 2007).

In addition, organizations should establish a method (or procedure) of accountability for CLAS activities throughout the organization's hierarchy, from the front desk to the senior executive level. All members of the organization should be trained and supported in making their day-to-day responsibilities culturally and linguistically appropriate and should be evaluated based on criteria relevant to CLAS and their role(s) within the organization (see Standard 4).

The National Quality Forum includes integration of cultural competency into management systems and operations as one of its seven primary domains for measuring and reporting cultural competency. Specifically, the National Quality Forum notes that a focus "on whether cultural competency is integrated throughout all management and operations activities of the organization is an essential component of supporting the delivery of culturally competent care" (National Quality Forum, 2009, p. iv).

Strategies for Implementation

The following are possible implementation strategies for infusing CLAS goals, policies, and management accountability throughout the organization's planning and operations:

- Engage the support of governance and leadership, and encourage the allocation of resources to support the development, implementation, and maintenance of culturally and linguistically appropriate services.
- Encourage governance and leadership to establish education and training requirements relating to culturally and linguistically appropriate services for all individuals in the organization, including themselves.
- Identify champions within and outside the organization to advocate for CLAS, to emphasize the business case and rationale for CLAS, and encourage full-scale implementation.
- Hold organizational retreats to identify goals, objectives, and timelines to provide culturally and linguistically appropriate services.
- Establish accountability mechanisms throughout the organization, including staff evaluations, individuals' satisfaction measures, and quality improvement measures (QSource, 2005).
- Utilize the data gathered based on Standards 10, 11, and 12 to guide plan development.
- In accordance with Standard 13, involve the populations in the service area in the implementation of CLAS through the strategic plan.

Resources

Betancourt, J. R., Weissman, J. S., Kim, M. K., Park, E., & Maina, A. W. (2007). *Resident physicians' preparedness to provide cross-cultural care: Implications for clinical care and medical education policy.* Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/1026_Betancourt_resident_MDs_preparedness_provide_cross-cultural_care.pdf

The Joint Commission. (2007). *"What did the doctor say?": Improving health literacy to protect patient safety.* Retrieved from http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf

Roat, C. (2003). *How to choose and use a language agency: A guide for health and social service providers who wish to contract with language agencies.* Retrieved from The California Endowment website: http://www.calendow.org/uploadedFiles/how_to_choose_use_language_agency.pdf

Weech-Maldonado, R. (2007, June). *Moving towards culturally competent health systems: Organizational and market factors.* Presented at the AcademyHealth Disparities Interest Group Meeting, Miami, FL. Retrieved from http://www.academyhealth.org/files/interestgroups/disparities/weech-maldonador.pdf

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

American Medical Association. (2006). *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations.* Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf

National Quality Forum. (2009). *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Retrieved from http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

Weech-Maldonado, R. (2002). *Organizational support standards for culturally and linguistically appropriate services (CLAS): Core concepts, content knowledge, and core skills.* Retrieved from https://www.thinkculturalhealth.hhs.gov/pdfs/PhysiciansConceptPaper_Weech_Maldanado.pdf

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf

Standard 10: Conduct Organizational Assessments

Standard 10

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Purpose

The purposes of conducting organizational assessments are:

- To assess performance and monitor progress in implementing the National CLAS Standards
- To obtain information about the organization and the people it serves, which can be used to tailor and improve services
- To assess the value of CLAS-related activities relative to the fulfillment of governance, leadership, and workforce responsibilities

Components of the Standard

Conduct ongoing assessment of the organization's CLAS-related activities

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

In general, the continuous quality improvement process for CLAS includes an assessment phase, a planning phase, an implementation phase, and an evaluation phase (Briefer French et al., 2008). As a key initial step in the continuous quality improvement process, organizational self-assessment is often used to examine factors that might enable or impede a service delivery system's effectiveness and performance. It is essential for planning, implementing, and evaluating the quality of any kind of service, including CLAS. To address organizational readiness for providing CLAS, The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010) calls on hospitals to "conduct an

organization assessment that measures baseline performance on specific issues to know where improvement might be necessary, detect gaps and areas of excellence, and tailor improvement interventions."

Organizational assessments range in intensity from relatively brief self-assessments using input solely from those in supervisory and/or administrative positions (e.g., organizational checklists), to in-depth assessments with structured and formal input from stakeholders, patients, consumers, and/or staff. In addition, they employ data collection methods ranging from informal interviews with senior leaders to using validated surveys across the organization. Ultimately, they produce outputs ranging from general and broad guidance to benchmarked and validated scores across multiple domains of performance.

A cultural audit is an assessment strategy used to examine, among other factors, an organization's values, symbols, and routines and identify problems that affect the organization's ability to provide services (Rice, 2005, 2008). A cultural audit may be used specifically to develop CLAS. With regard to cultural and linguistic competency, many organizations may remain largely unaware of structural, procedural, and behavioral factors that create barriers to providing quality services for diverse populations. A cultural audit and self-assessment may increase awareness within the organization by facilitating the identification of unique group characteristics that can be used to ensure service access and treatment and the identification of opportunities for the organization to better market itself to diverse populations (Andrulis, Delbanco, Avakian, & Shaw-Taylor, 2001). Although many health and health care organizations are attempting to provide CLAS through targeted programs, research suggests that they rarely perform optimally across the range of issues associated with CLAS (Wynia et al., 2010). Too often, these efforts are not linked with other organizational activities that focus on policy and decision-making related to outcomes accountability. A comprehensive audit, however, can help organizations identify the existing gaps between CLAS programming and initiatives and widespread organizational policies that can support, sustain, and ultimately improve such initiatives (Wynia et al., 2010).

Integrate CLAS-related measures into measurement and continuous quality improvement activities

Integrating measures related to cultural and linguistic competency into existing assessment efforts and continuous quality improvement programs helps organizations learn whether CLAS delivery processes are producing the desired results. Without incorporating such measures into assessment, planning, implementation, and evaluation

efforts, organizations will not be able to demonstrate successfully the effectiveness of CLAS delivery, nor will they be able to identify ways to improve CLAS implementation.

CLAS-related measures in performance improvement and outcomes assessments include but are not limited to:

- Accessibility of interpreter services
- Effectiveness of cultural and linguistic competency training for providers and nonclinical staff
- Differences in the use of services among diverse populations
- Impact of culturally and linguistically competent service provision on health outcomes and health status and on individuals' satisfaction

Strategies for Implementation

The following are possible implementation strategies for conducting organizational assessments:

- Conduct an organizational assessment or a cultural audit using existing cultural and linguistic competency assessment tools to inventory structural policies, procedures, and practices. These tools can provide guidance to determine whether the core structures and processes (e.g., management, governance, delivery systems, and customer relation functions) necessary for providing CLAS are in place.
- Use results from assessments to identify assets (e.g., bilingual staff members who could be used as interpreters, existing relationships with community-based ethnic organizations), weaknesses (e.g., no translated signage or cultural competency training), and opportunities to improve the organization's structural framework and capacity to address cultural and linguistic competence in care (e.g., revise mission statement, recruit people from diverse cultures into policy and management positions).
- Following the assessment, prepare adequate plans for developing CLAS (see Standard 9). Subsequent ongoing assessment helps organizations to monitor their progress in implementing the enhanced National CLAS Standards and to refine their strategic plans.

The following are implementation strategies for integrating CLAS-related measures into measurement and continuous quality improvement activities (QSource, 2005):

- Implement ongoing organizational assessment of CLAS-related activities
- Provide individuals with CLAS-oriented feedback forms and include self-addressed, stamped envelopes to improve receipt of feedback
- Conduct focus groups with individuals to monitor progress and identify barriers to full-scale CLAS implementation
- Assess the standard of care provided for various chronic conditions to determine whether services are uniformly provided across cultural groups
- Add CLAS-related questions to staff orientation materials and yearly reviews
- Develop a system of reviewing and incorporating feedback and suggestions received and for monitoring their effect on CLAS implementation and outcomes
- Identify outcome goals, including metrics, regarding cultural and linguistic competency and assess at regular intervals

Resources

American Medical Association. (n.d.). *Communication climate assessment toolkit.* Retrieved from http://www.ama-assn.org/go/ccat

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., ... Powe, N. R. (2004). *Strategies for improving minority healthcare quality* (AHRQ Publication No. 04-E008-02). Retrieved from Agency for Healthcare Research and Quality website: http://archive.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Campinha-Bacote, J. (2002). *Inventory for assessing the process of cultural competence among healthcare professionals-Revised (IAPCC-R).* Retrieved from http://www.transculturalcare.net/iapcc-r.htm

Drucker, P. F. (1998). *The Drucker Foundation self-assessment tool: Participant workbook.* Hoboken, NJ: Jossey-Bass, Inc.

Hasnain-Wynia, R., & Baker, D. W. (2006). Obtaining data on patient race, ethnicity, and primary language in health care organizations: Current challenges and proposed solutions. *Health Services Research, 41,* 1501–1518. doi:10.1111/j.1475-6773.2006.00552.x

Johns Hopkins University. (2010). *COA360.* Retrieved from www.COA360.org

National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center. (n.d.). *Cultural competence health practitioner assessment (CCHPA).* Retrieved from http://nccc.georgetown.edu/features/CCHPA.html

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2008). Hospital language services: Quality improvement and performance measures. In *Advances in patient safety: New directions and alternative approaches, Volume 2. Culture and redesign* (AHRQ Publication No. 08-0034-2). Retrieved from http://www.ncbi.nih.gov/books/NBK43719

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *Surveys on patient safety culture*. Retrieved from http://www.ahrq.gov/qual/patientsafetyculture/

Vogt, K. (2006, September). Mystery shopping gaining popularity in health care sector: The rise of consumer-directed care is one reason why physicians, hospitals and health plans are sending people incognito to learn how things are working. *American Medical News.* Retrieved from http://www.ama-assn.org/amednews/2006/09/18/bise0918.htm

Wang, S. (2006, August 8). Health care taps "mystery shoppers": To improve service, hospitals and doctors hire spies to pose as patients and report back. *Wall Street Journal.* Retrieved from http://online.wsj.com/article/SB115499684792929340.html

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Andrulis, D., Delbanco, T., Avakian, L., & Shaw-Taylor, Y. (2001). *Conducting a cultural competence self-assessment*. Retrieved from http://erc.msh.org/provider/andrulis.pdf

Briefer French, J., Schiff, D., Han, E., & Weinick, R. (2008). *Multicultural health care: A quality improvement guide.* Retrieved from National Committee for Quality Assurance website: http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf

The Joint Commission. (2010). A*dvancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

Rice, M. F. (2005). Teaching public administration education in the post modern era. In M. F. Rice (Ed.), *Diversity and public administration: Theory, issues, and perspectives* (pp. 87–103). Armonk, NY: Sharpe.

Rice, M. F. (2008). A primer for developing a public agency service ethos of cultural competency in public services programming and public services delivery. *Journal of Public Affairs Education, 14,* 21–38.

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Standard 11: Collect and Maintain Demographic Data

Standard 11

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Purpose

The purposes of collecting and maintaining demographic data are:

- To accurately identify population groups within a service area
- To monitor individual needs, access, utilization, quality of care, and outcome patterns
- To ensure equal allocation of organizational resources
- To improve service planning to enhance access and coordination of care
- To assess and improve to what extent health care services are provided equitably

Components of the Standard

Collect and maintain accurate and reliable demographic data

Health and health care organizations should collect key data from individuals using personnel trained in cultural and linguistic competency. Data collected should include demographic information such as race, ethnicity, sex, language, and disability status (HHS, 2011ab). When elements of such data are collected in different ways across different sectors of the health and health care system and by separate organizations, the data are fragmented and often poorly integrated (IOM, 2009; National Research Council, 2009).

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

The availability of demographic data, particularly race and ethnicity, is the first step in being able to demonstrate the effectiveness of CLAS in the delivery of quality, equitable

care and, ultimately, in reducing disparities (Hasnain-Wynia & Baker, 2006; Nerenz, 2005; HHS, 2011b). Other reasons to collect data pertaining to CLAS are (Massachusetts Department of Public Health, Office of Health Equity, 2009):

- To meet state and federal reporting requirements, including new requirements being implemented under health reform
- To establish the foundation for cultural and linguistic competency
- To become more responsive to cultural preferences
- To tailor services to diverse needs
- To use resources more cost effectively
- To become more competitive in the market place

In organizations with multiple points of entry, information collected at one point should be routinely shared across other service sectors or departments consistent with the confidentiality requirements (see p119). Ideally, for programs requiring enrollment (e.g., managed care programs), the person responsible for enrollment would collect these data and then share the information with the provider. In other cases, health professionals, such as physicians or pharmacists, could collect and record this information at the first point of contact (Wynia, Ivey, & Hasnain-Wynia, 2010). The information should be included in the individual's record and communicated to other departments that might have contact with the individual, such as billing or member services. The utilization of electronic health records and other health information technology (HIT) systems could significantly facilitate this sharing of data within and between organizations (IOM, 2009).

To ensure the accuracy and reliability of the data collected, organizations should facilitate processes that allow for self-identification and avoid use of observational/visual assessment methods, the latter of which is considered to be less reliable (Hasnain-Wynia & Baker, 2006; Hasnain-Wynia, Pierce, & Pittman, 2004; Higgins & Taylor, 2009). If a demographic variable (e.g., race) has more than one category, individuals should be allowed to indicate all categories that apply. In addition, with the increased adoption of health information technology, organizations have another way to improve upon the collection and exchange of reliable data (IOM, 2009).

In October 2011, the U.S. Department of Health and Human Services released implementation guidance for the collection of race, ethnicity, sex, primary language, and disability status data (HHS, 2011b). The purpose of the guidance was to promulgate a set

of uniform data collection standards for inclusion in population-health surveys conducted or sponsored by HHS as required by Section 4302 of the Affordable Care Act.

In addition to the standards below, HHS is developing a national data progression plan on sexual orientation and gender identity variables. *The Blueprint* will be updated accordingly to reflect the most current HHS requirements.

The HHS implementation guidance is clear in its intent that the data collection standards represent the minimum, not the maximum, requirements. The variables noted in the guidance are not intended to limit the collection of needed data. Agencies are encouraged to collect additional data as needed, as long as the minimum standard is included, the data can be aggregated up to the minimum standard (in the case of race and ethnicity), and the sample size supports those estimates. For the disability data standard, although survey questions and answer categories included in the standard cannot be changed, additional disability questions may be included.

HHS Data Collection Standards (HHS, 2011a)

- ***Ethnicity Data Standard***
  - *Are you of Hispanic, Latino/a, or Spanish origin? (One or more categories may be selected).*
    - No, not of Hispanic, Latino/a, or Spanish origin
    - Yes, Mexican, Mexican American, Chicano/a
    - Yes, Puerto Rican
    - Yes, Cuban
    - Yes, Another Hispanic, Latino/a, or Spanish origin

These categories roll up to the Hispanic or Latino category of the Office of Management and Budget (OMB) Standard.

- ***Race Data Standard***
  - *What is your race? (One or more categories may be selected).*
    - White
    - Black or African American
    - American Indian or Alaska Native

These categories are part of the current OMB standard.

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

These categories roll-up to the Asian category of the OMB Standard.

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

These categories roll-up to the Native Hawaiian or Other Pacific Islander category of the OMB Standard.

- ***Sex Data Standard***
  - *What is your sex?*
    - Male
    - Female

- ***Primary Language Data Standard***
  - *How well do you speak English? (5 years old or older)*
    - Very well
    - Well
    - Not well
    - Not at all

  Recommended additional questions
  - *Do you speak a language other than English at home? (5 years old or older)*
    - Yes
    - No

  For persons speaking a language other than English (answering yes to the question above):
  - *What is this language? (5 years old or older)*
    - Spanish
    - Other Language (Identify)

- ***Disability Status Data Standard***

- *Are you deaf or do you have serious difficulty hearing?*
  - Yes
  - No
- *Are you blind or do you have serious difficult seeing, even when wearing glasses?*
  - Yes
  - No
- *Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)*
  - Yes
  - No
- *Do you have serious difficulty walking or climbing stairs? (5 years old or older)*
  - Yes
  - No
- *Do you have difficulty dressing or bathing? (5 years old or older)*
  - Yes
  - No
- *Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone, such as visiting a doctor's office or shopping? (15 years old or older)*
  - Yes
  - No

To monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

Ultimately, one purpose of collecting and maintaining accurate demographic data is to utilize the data in organizational monitoring, evaluation, and continuous quality improvement activities (IOM, 2009; Wynia et al., 2010). In addition, while the assessment of health disparities and inequities is complex and entails linking demographic data with other types of data (e.g., service data, quality of care data), the availability of accurate and reliable demographic data is key in documenting such issues and developing strategies to address them (Bilheimer & Klein, 2010; Hasnain-Wynia & Baker, 2006; IOM, 2009; Lurie & Fremont, 2006).

Organizations may use demographic data to determine basic information about trends in organizational and health care utilization, such as the total number of visits made to emergency departments based on race/ethnicity and gender or the total number of individuals requesting language assistance. This information could then be used to make staffing assignment decisions or determine the need for additional language assistance

resources. When linked with other data, health and health care organizations can make increased data-informed decisions and improve the quality of care, consistent with quality improvement activities (Fiscella, 2011). For example, in response to changing state regulations on the collection of race/ethnicity/language data, several hospitals in Massachusetts began linking these data with performance and quality measures to identify disparities in health and health care, develop targeted programs for employees concerning cultural competency, and develop targeted interventions to engage individuals from specific populations (Jorgensen, Thorlby, Weinick, & Ayanian, 2010).

Current surveys and data collection tools may not encompass all demographic groups in a particular area or region. For example, although lesbian, gay, bisexual and transgender related data have been collected on several surveys in the past, there are a number of challenges (HHS, 2012). This can limit the ability to estimate population size and address health needs. Organizations should sensitively and strategically utilize, and develop if necessary, survey instruments that will encompass the various demographic groups in their community. Partnerships, as described in Standard 13, can assist in the identification and development of such instruments.

Confidentiality Issues

In collecting data, organizations will likely encounter issues related to confidentiality. Many individuals may be hesitant to provide personal information, such as race, ethnicity, and language, due to concerns about privacy or fear of negative reprisals (IOM, 2009; Robert Wood Johnson Foundation, 2004). Individuals may believe that they will receive disparate services based on their answers to questions about race, ethnicity, primary language, gender identity, or sexual orientation in a health or service encounter. Still others may worry about being asked to pay higher insurance premiums based on race, ethnicity, or would either say medical condition or pre-existing condition.

Data collection should not be at the detriment of the relationship between the individual and the health care or service provider, and the individual should not be put at risk to collect such data. Just as important is the organization's obligation to inform individuals and, ideally, all groups in the community about the purpose of collecting such data, the intended uses of the data, and the individual's right to withhold the data. Individuals need to be assured that the information is being gathered for legitimate purposes, and they should be notified as to the circumstances in which their data will be shared (AHRQ, 2011; Lurie & Fremont, 2006). In addition to following ethical principles and standards, health care organizations should follow the federal regulation concerning the privacy of health

information. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 requires health care organizations and providers to collect, use, and/or disclose individually identifiable data and information only to the extent necessary to accomplish a specific purpose and to obtain consent for both routine and nonroutine use and disclosure of health records. The regulation also calls for organizations and providers to provide a clear, written explanation of how health information can and will be used, kept, and disclosed (HHS ODPHP, 2000).

To maintain the confidentiality and privacy of potentially identifiable data, there are a number of options organizations and providers could choose. For example, organizations and providers could de-identify the data or use codes for data, such as race and ethnicity information, that would not be linked to individuals' names. These de-identified data could then be analyzed and reported in aggregate to monitor disparities and measure outcomes. In addition, organizations could clarify the purpose of the data to staff and specify which staff members may have access to the data. In establishing and enforcing data collection and access policies and procedures, organizations should also ensure that all staff members with data access regularly receive training on client record confidentiality (HHS OMH, 2001).

Strategies for Implementation

The following are possible implementation strategies for collecting and maintaining demographic data:

Table 4: A Process for Collecting Data

When?	Ask for data early — ideally, during admission or registration	
Who?	Properly trained admissions or reception staff could collect data	
What will you tell individuals?	Before obtaining information, develop a script to communicate that: • This information is important. • It will be used to improve care and services and to prevent discrimination. • This information will be kept confidential. In addition, address any concerns up front and clearly.	
How?	Individual self-report — select their own race, ethnicity, language, etc.	
What information will you collect?	Individual Data: • Race • Ethnicity • Nationality • Nativity	Staff Data: • Race • Ethnicity • Nationality • Nativity

	• Ability to speak English • Language(s) other than English spoken • Preferred spoken/written languages or other mode of communication • Age • Gender • Sexual orientation • Gender identity • Income • Education • Informed of right to interpreter services • Request for, and/or use of, interpreter services • Treatment history • Medical history • Outcome data (service type, utilization, length of stay) • Client satisfaction See also aforementioned HHS Data Collection Standards	• Primary/preferred language • Gender • Records of cultural and linguistic competency training participation and evaluations
Tools to collect and store data	Use standard collection instruments. Store data in a standard electronic format.	
Training	Provide ongoing data training and evaluation to staff	
(Massachusetts Department of Public Health, Office of Health Equity, 2009) Adapted from the Health Research and Evaluation Trust Health Disparities Toolkit (Hasnain-Wynia et al., 2007)		

Resources

Asset-Based Community Development Institute. (2009). Retrieved from http://www.abcdinstitute.org/

Baker, Q. E., Davis, D. A., Gallerani, R., Sanchez, V., Viadro, C., & The Center for the Advancement of Community Based Public Health. (2000). *An evaluation framework for community health programs.* Retrieved from http://www.doh.state.fl.us/COMPASS/documents/Community_Health_Programs_Eval.pdf

Hasnain-Wynia, R., Van Dyke, K., Youdelman, M., Krautkramer, C., Ivey, S., Gilchick, R., Kaleba, E., & Wynia, M. K. (2010). Barriers to collecting patient race, ethnicity and primary language data in physician practices: An exploratory study. *Journal of the National Medical Association, 102*(9), 769–775.

Sharpe, P. A., Greaney, M. L., Lee, P. R., & Royce, S. W. (2000). Assets-oriented community assessment. *Public Health Reports, 115,* 205–211. Retrieved from

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308712/pdf/pubhealthrep00022-0103.pdf

U.S. Department of Commerce, Census Bureau. (n.d.). *American factfinder.* Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS cultural competence item set.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/cultural-competence.aspx

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS item set for addressing health literacy.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/health-literacy.aspx

U.S. Department of Health and Human Services, Office of Minority Health. (2011). *Final data collection standards for race, ethnicity, primary language, sex, and disability status required by Section 4302 of the Affordable Care Act.* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

U.S. Department of Health and Human Services. (2011). *Improving data for the LGBT community.* Retrieved from http://www.healthcare.gov/news/factsheets/2011/06/lgbt06292011a.html

Wynia, M., Hasnain-Wynia, R., Hotze, T. D., & Ivey, S. L. (2011). *Collecting and using race, ethnicity and language data in ambulatory settings: A white paper with recommendations from the Commission to End Health Care Disparities.* Retrieved from American Medical Association website: http://www.ama-assn.org/resources/doc/public-health/cehcd-redata.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Bilheimer, L. T., & Klein, R. J. (2010). Data and measurement issues in the analysis of health disparities. *Health Services Research, 45,* 1489–1507. doi:10.1111/j.1475-6773.2010.01143.x

Fiscella, K. (2011). Eliminating disparities in health care through quality improvement. In R. A. Williams (Ed.), *Healthcare disparities at the crossroads with healthcare reform* (pp. 231–267). New York, NY: Springer.

Hasnain-Wynia, R., & Baker, D. W. (2006). Obtaining data on patient race, ethnicity, and primary language in health care organizations: Current challenges and proposed solutions. *Health Services Research, 41,* 1501–1518. doi:10.1111/j.1475-6773.2006.00552.x

Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., & Reiter, J. (2007). *Health Research and Educational Trust disparities toolkit.* Retrieved from http://www.hretdisparities.org/

Hasnain-Wynia, R., Pierce, D., & Pittman, M. A. (2004). *Who, when, and how: The current state of race, ethnicity, and primary language data collection in hospitals* (Commonwealth Fund Publication No. 726). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2004/May/Who%20%20When%20%20and%20How%20%20The%20Current%20State%20of%20Race%20%20Ethnicity%20%20and%20Primary%20Language%20Data%20Collection%20in%20Ho/hasnain%20wynia_whowhenhow_726%20pdf.pdf

Higgins, P. C., & Taylor, E. F. (2009). *Measuring racial and ethnic disparities in health care: Efforts to improve data collection.* Retrieved from Mathematica Policy Research website: http://www.mathematica-mpr.com/pdfs/health/DisparitiesHealthcare.pdf

Institute of Medicine. (2009). *Race, ethnicity, and language data: Standardization for health care quality improvement*. Retrieved from http://iom.edu/Reports/2009/RaceEthnicityData.aspx

Jorgensen, S., Thorlby, R., Weinick, R. M., & Ayanian, J. Z. (2010). Responses of Massachusetts hospitals to a state mandate to collect race, ethnicity and language data from patients: A qualitative study. *BMC Health Services Research, 10,* 352–359. doi:10.1186/1472-6963-10-352

Lurie, N., & Fremont, A. (2006). Looking forward: Cross-cutting issues in the collection and use of racial/ethnic data. *Health Services Research, 41,* 1519–1533. doi:10.1111/j.1475-6773.2006.00553.x

Massachusetts Department of Public Health, Office of Health Equity. (2009). *Making CLAS happen: Six areas for action*. Retrieved from http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/health-equity/clas/making-clas-happen.html

National Research Council. (2009). *Principles and practices for a federal statistical agency* (4th ed.). Retrieved from http://www.nap.edu/catalog.php?record_id=12564

Nerenz, D. R. (2005). Health care organizations' use of race/ethnicity data to address quality disparities. *Health Affairs, 24,* 409–416. doi:10.1377/hlthaff.24.2.409.

Robert Wood Johnson Foundation. (2004). *Key findings from a national survey conducted among adults who have health care coverage on behalf of the Robert Wood Johnson Foundation on the issue of disparities in health care.* Retrieved from http://www.rwjf.org/files/newsroom/POSfullMemo.pdf

U.S. Department of Health and Human Services. (2011a). *Implementation guidance on data collection standards for race, ethnicity, sex, primary language, and disability status*. Retrieved from http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.pdf

U.S. Department of Health and Human Services. (2011b). *HHS action plan to reduce racial and ethnic disparities: A nation free of disparities in health and health care*. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services. (2012). *Lesbian, gay, bisexual, and transgender health.* Retrieved from http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *New communication protocols, inclusive policies, and ongoing training lead to culturally competent care for lesbian, gay, bisexual, and transgender patients.* Retrieved from http://www.innovations.ahrq.gov/content.aspx?id=2737

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2000). *Healthy people 2010: Understanding and improving health.* Retrieved from http://www.healthypeople.gov/2010/Document/tableofcontents.htm#under

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Wynia, M. K., Ivey, S. L., & Hasnain-Wynia, R. (2010). Collection of data on patients' race and ethnic group by physician practices. *New England Journal of Medicine, 362,* 846–850.

Standard 12: Conduct Assessments of Community Health Assets and Needs

Standard 12

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Purpose

The purposes of conducting assessments of community health assets and needs are:

- To determine the service assets and needs of the populations in the service areas (needs assessment)
- To identify all of the services available and not available to the populations in the service areas (resource inventory and gaps analysis)
- To determine what services to provide and how to implement them, based on the results of the community assessment
- To ensure that health and health care organizations obtain demographic, cultural, linguistic, and epidemiological baseline data (quantitative and qualitative) and update the data regularly to better understand the populations in their service areas

Components of the Standard

Conduct Regular Assessments of Community Health Assets and Needs

An effective model for knowing and understanding one's community and how best to serve it is a community services assessment.

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

A community services assessment is composed of three parts (AED Center on AIDS & Community Health, 2005):

- Needs Assessment
- Resource Inventory
- Gaps Analysis

Community services assessments are currently used in various areas of public and community health, including AIDS prevention (HHS CDC, 2003). The cultural knowledge they provide can help organizations better utilize community assets and develop or adapt existing services to better meet community needs. A community services assessment helps an organization understand its community by identifying individuals from the populations in the service area who may need specific, tailored interventions due to cultural or linguistic differences. A community services assessment may also aid in the development of culturally and linguistically appropriate services by helping to identify and define the dynamics of difference between organizations and the populations they serve, especially those involving health beliefs, attitudes toward health and health care, and perceptions of effective health communication. It also allows an organization to avoid duplication in the creation or promotion of services via identification of the assets already utilized in the community. These data can be used for the development or adaptation of services to address unmet needs (e.g., incorporating assets in the development or adaptation of services) and to provide a framework within which services can be evaluated.

Once key stakeholders from the populations in the service area are identified, an organization will be better able to establish partnerships with community-based organizations, faith-based organizations, and nonprofit or nongovernmental organizations within the service area. These partnerships will not only improve access to and utilization of services through improved awareness, but they may also increase an individual's perceived satisfaction with those services. Community support and insight facilitate the implementation of culturally and linguistically appropriate services and policies.

Plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

Conducting a community needs assessment should be just the first step in a comprehensive effort to engage local communities in organizational planning and operations (see Standard 13). Data and information collected from regular community assessments can be used to develop a comprehensive profile of the populations in the

service area, which could have significant demographic and epidemiological value. Such a profile would help organizations, providers, and policymakers develop appropriate services and evaluate access to and utilization of those services over time. In addition, data from this profile could be used to generate more specific profiles (e.g., linguistic or geographic profiles) that could be used to inform targeted service development and service delivery plans.

According to The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (2010), health and health care organizations should develop and maintain community profiles to:

- Allow organizations to plan for the services necessary to meet individuals' and groups' needs
- Identify and respond to changes in the demographics of the surrounding community
- Identify potential disparities in care or services
- Plan for services to meet unique individual needs
- Identify language needs of the population
- Provide appropriate language services to meet those needs

Strategies for Implementation

The following are possible implementation strategies for assessing community health assets and needs.

- Partner with other organizations to negotiate a data sharing agreement, which could facilitate the linking of different types of data.
- Collaborate with other organizations and stakeholders in data collection, analysis, and reporting efforts to increase data reliability and validity.
- Conduct focus groups with individuals in the community (QSource, 2005).
- Review demographic data collected with local health and health care organizations (QSource, 2005).
- Use multiple sources in the community to collect data, including faith-based organizations, social workers, and managed care organizations (QSource, 2005).

The HHS Administration for Children and Families' Head Start initiative recommends the following Outline for Assessing Community Needs and Resources (HHS Administration for Children and Families, 2008; University of Kansas, n.d.):

1. Describe the makeup and history of the community to provide a context within which to collect data on its current concerns.
   a. Comment on the types of information that best describe the community (e.g., demographic, historical, political, civic participation, key leaders, past concerns, geographic, assets)
   b. Describe the sources of information used (e.g., public records, local people, Internet, maps, phone book, library, newspaper)
   c. Comment on whether there are sufficient resources available to collect this information (e.g., time, personnel, resources)
   d. Describe the methods used to collect descriptive information (e.g., public forums, listening sessions, focus groups, interviews, surveys, observation)
   e. Assess the quality of the information
   f. Describe the strengths and difficulties identified
2. Describe what matters to people in the community, including a description of:
   a. Issues that people in the community care about (e.g., safety, education, housing, health)
   b. How important these issues are to the community (e.g., perceived importance, consequences for the community)
   c. Methods the organization will (did) use to listen to the community (e.g., listening sessions, public forums, interviews, concerns surveys, focus groups)
3. Describe what matters to key stakeholders, including:
   a. Who else cares about the issue (the stakeholders) and what they care about
   b. What stakeholders want to know about the situation (e.g., who is affected, how many, what factors contribute to the problem)
   c. Prioritized populations and subgroups to whom stakeholders are targeting benefits
   d. Methods used to gather information (e.g., surveys, interviews)
4. (For each identified problem/goal) Describe the evidence indicating whether the problem/goal should be a priority issue, including:
   a. The community-level indicators related to the issue (e.g., rate of infant deaths or vehicle crashes)

   b. How frequently the problem (or related behavior) occurs (e.g., number of youth reporting alcohol use in the past 30 days)
   c. How many people are affected by the problem and the severity of its effects
   d. How feasible it is to address the issue
   e. Possible impact and/or consequences of addressing the problem/goal
5. Describe the barriers and resources for addressing the identified issue(s), including:
   a. Barriers or resistance to solving the problem or achieving the goal (e.g., denial or discounting of the problem) and how they can be minimized (e.g., reframing the issue)
   b. What resources and assets are available and how the organization can tap into those resources to address the issue
   c. Community context or situation that might make it easier or more difficult to address this issue
6. (Based on the assessment) Select and state the priority issue (or issues) to be addressed by the organization.

Resources

Asset-Based Community Development Institute. (2009). Retrieved from http://www.abcdinstitute.org/

Aubel, J. (1999). *Participatory program evaluation manual: Involving program stakeholders in the evaluation process*. Retrieved from http://www.idrc.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf

Baker, Q. E., Davis, D. A., Gallerani, R., Sanchez, V., Viadro, C., & The Center for the Advancement of Community Based Public Health. (2000). *An evaluation framework for community health programs*. Retrieved from http://www.doh.state.fl.us/COMPASS/documents/Community_Health_Programs_Eval.pdf

Clinical and Translational Science Awards Consortium, Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. (2011). *Principles of community engagement* (2nd ed.) (National Institutes of Health Publication No. 11-7782). Retrieved from http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Sharpe, P. A., Greaney, M. L., Lee, P. R., & Royce, S. W. (2000). Assets-oriented community assessment. *Public Health Reports, 115,* 205–211. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308712/pdf/pubhealthrep00022-0103.pdf

University of Washington, Community-Campus Partnerships for Health. (n.d.). *Community-based participatory research.* Retrieved from http://depts.washington.edu/ccph/commbas.html

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

AED Center on AIDS & Community Health. (2005). *HIV prevention community planning: An orientation guide*. Retrieved from http://www.cdc.gov/hiv/topics/cba/resources/guidelines/Orientation_Final.pdf

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

University of Kansas. (n.d.). *Assessing community needs and resources: Outline for assessing community needs and resources*. Retrieved from http://ctb.ku.edu/en/dothework/tools_tk_content_page_77.aspx

U.S. Department of Health and Human Services, Administration for Children and Families. (2008). *Outline for assessing community needs and resources: Assessing community needs and resources*. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/operations/Fiscal/Grants/Community%20Assessment/fiscal_art_00177_090205.html

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2003). *HIV prevention: Community planning guide*. Retrieved from http://www.cdc.gov/hiv/pubs/hiv-cp.pdf

Standard 13: Partner with the Community

Standard 13

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Purpose

The purpose of partnering with the community is:

- To provide responsive and appropriate service delivery to a community
- To ensure that services are informed and guided by community interests, expertise, and needs
- To increase use of services by engaging individuals and groups in the community in the design and improvement of services to meet their needs and desires
- To create an organizational culture that leads to more responsive, efficient, and effective services and accountability to the community
- To empower members of the community in becoming active participants in the health and health care process

Components of the Standard

Partner with the community

Community partnerships are an essential component in the provision of cultural and linguistic competency. Only through meaningful community partnerships can an organization truly understand the individual needs of the diverse population it serves, appropriately allocate resources, and develop an accountable system that provides equitable culturally and linguistically appropriate care and services (Douglas et al., 2009; Wu & Martinez, 2006). In addition, community engagement has been found to

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

be strongly correlated with higher patient-reported quality of care and trust (Wynia et al., 2010).

Design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

Input from individuals in the community is essential to planning, implementing, and improving services. Community input provides health and health care organizations with the opportunity to learn about and understand their reputation in the community. Designing, implementing, and evaluating services, all of which have been informed by community input, is particularly useful in improving the organization's reach and services. If an organization communicates messages that individuals in the community view as unrealistic — for example, advice to take a daily walk when there are concerns about neighborhood safety — the messages may not result in the desired behavior change and will be unproductive. Organizations will be more effective and will ultimately experience cost savings if they consider community input.

Strategies for Implementation

The following are implementation strategies for partnering with the community:

- Partner with local culturally diverse media to promote better understanding of available care and services and of appropriate routes for accessing services among all community members (Wilson-Stronks & Galvez, 2007).
- Build coalitions with community partners to increase reach and impact in identifying and creating solutions. For example:
    - *Work on joint steering committees and coalitions.*
    - *Sponsor or participate in health fairs, cultural festivals, and celebrations.*
    - *Offer education and training opportunities.*
- Convene town hall meetings, hold community forums, and/or conduct focus groups (Prevention by Design, 2006).
- Develop opportunities for capacity building initiatives, action research, involvement in service development, and other activities to empower the community (Equality and Human Rights Commission, 2009).
- Collaborate to reach more people, to share information and learn, and to improve services. Work with partners to advertise job openings, identify interpreting resources, and organize health promotion activities. Successful partnerships benefit all.

In addition, the following professionals and volunteers may facilitate communication between an organization and the community it serves:

- Cultural brokers are individuals from the community who can serve as a bridge between an organization and people of different cultural backgrounds. Cultural brokers should be familiar with the health system and with the community in which they live and/or from where they originated. They can become a valuable source of cultural information and serve as mediators in conflicts and as agents for change (Massachusetts Department of Public Health, 2009).
- Promotores de salud/community health workers are volunteer community members and paid front-line public health workers who are trusted members of the community served or have an unusually close understanding of that community. They generally share the ethnicity, language, socio-economic status, and life experiences of the community members. These social attributes and trusting relationships enable community health workers to serve as liaisons, links, or intermediaries between health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competency of services (HHS OMH, 2011).

Resources

Association of the Bar of the City of New York. (n.d.). *Diversity committees that make a difference.* Retrieved from http://www.akcsystems.com/test3/images/stories/pdfs/Diversity%20Committee%20Notes%20Article10_2004.pdf

Baker, S., Conrad, D., Béchamps, M., & Barry M. (2002). *Healthy people toolkit 2010: A field guide to health planning.* Retrieved from Public Health Foundation website: http://www.phf.org/resourcestools/Documents/HP2010Toolkit2002.pdf

Clinical and Translational Science Awards Consortium, Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. (2011). *Principles of community engagement* (2nd ed.) (National Institutes of Health Publication No. 11-7782). Retrieved from http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Institute for Patient- and Family-Centered Care. (2011). *Tools to foster the collaboration with patient and family advisors.* Retrieved from http://www.ipfcc.org/tools/downloads-tools.html

Leonhardt, K., Bonin, D., & Pagel, P. (2008). *Guide for developing a community-based patient safety advisory council* (AHRQ Publication No. 08-0048). Retrieved from http://www.ahrq.gov/qual/advisorycouncil/advisorycouncil.pdf

Schillinger, D. (2010). *An introduction to effectiveness, dissemination and implementation research: A resource manual for community-engaged research.* Retrieved from http://accelerate.ucsf.edu/files/CE/edi_introguide.pdf

Summit Health Institute for Research and Education. (2004). *Building coalitions among communities of color: A multicultural approach.* Retrieved from http://www.shireinc.org/wp-content/files/Building_Coalitions_among_Communities_of_Color.pdf

Torres, G., & Margolin, F. (2003). *The collaboration primer: Proven strategies, considerations, and tools to get you started.* Retrieved from Health Research and Educational Trust website: http://www.hret.org/upload/resources/collaboration-primer.pdf

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS cultural competence item set.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/cultural-competence.aspx

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Douglas, M. K., Pierce, J. U., Rosenkoetter, M., Callister, L. C., Hattar-Pollara, M., Lauderdale, J., & Pacquiao, D. (2009). Standards of practice for culturally competent nursing care: A request for comments. *Journal of Transcultural Nursing, 20,* 257–269.

Equality and Human Rights Commission. (2009). *Good practice in community engagement from an equality perspective*. Retrieved from http://www.equalityhumanrights.com/uploaded_files/good_practice_in_community_engagement.pdf

Massachusetts Department of Public Health, Office of Health Equity. (2009). *Making CLAS happen: Six areas for action.* Retrieved from http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/health-equity/clas/making-clas-happen.html

Prevention by Design. (2006). *Community engagement strategies: Tip sheet*. Retrieved from http://socrates.berkeley.edu/~pbd/pdfs/Community_Engagement_Strategies.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2011). *Definition of promotoras de salud*. Retrieved from http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=207&ID=8930

Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund

website:
http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf

Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Standard 14: Create Conflict and Grievance Resolution Processes

Standard 14

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Purpose

The purposes of creating conflict and grievance resolution processes that are culturally and linguistically appropriate are:

- To facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations
- To anticipate, identify, and respond to cross-cultural needs
- To meet federal and/or state level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and procedures

Components of the Standard

Create conflict and grievance resolution processes that are culturally and linguistically appropriate

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

As documented in the HHS Agency for Healthcare Research and Quality's 2011 National Healthcare Quality Report and National Healthcare Disparities Report, access to quality health care remains suboptimal, particularly for minority and low-income groups (2012). One contributing factor of health disparities is the existence of discriminatory, inequitable practice (IOM, 2003). Culturally and linguistically appropriate conflict and grievance resolution processes address the discrimination and unfair treatment — actual and perceived — of diverse populations. Discrimination based on race, ethnicity, sex, age, socioeconomic status, sexual orientation,

gender identity, and other characteristics impede the provision of quality care and services, making culturally and linguistically competent conflict prevention and resolution a vital part of advancing health equity.

Individuals from diverse backgrounds may encounter situations in which their needs and preferences are not accommodated or respected by the organization or its staff. These situations may range from differences related to informed consent and advance directives, to difficulty in accessing services or denial of services, to discriminatory treatment (HHS OMH, 2001). While personal preferences for care should be accommodated as much as possible and equitable nondiscriminatory treatment should be guaranteed, it is inevitable that individuals will have conflicts and grievances. To address this, organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts and must develop a method through which individuals can provide feedback. All individuals must then be informed about, and have access to, these feedback procedures that cover all aspects of their interaction with the organization (HHS OMH, 2001).

Organizations should anticipate and be responsive to the differences that arise between individuals and the organization and its staff. This responsiveness may be achieved by integrating principles of cultural sensitivity into existing feedback procedures, as well as into policies, programs, and committees charged with responsibility for patient relations and legal or ethical issues. When existing structures are inadequate, new approaches may need to be developed.

As addressed in Standard 4, governance, leadership, and staff should be trained in cultural and linguistic competency so that they are prepared to respond appropriately to feedback received by individuals or groups in their service area. Procedural guidelines, courses, and case study analysis can educate staff on how to listen and respond respectfully. Appropriate training and procedural guidelines will allow staff to respond to all feedback, including complaints. Organizations should also create programs with an ombudsperson and a diverse staff to proactively address individuals' rights and protections. Such a program can provide another quality feedback loop on the effectiveness of ongoing cultural and linguistic competency initiatives. The feedback process should be understandable, easily accessible, confidential, and transparent.

Health and health care organizations should not assume that a lack of conflict or complaints equates to satisfaction with services or care provided. Individuals may have fears or cultural beliefs that inhibit criticism or may not know that they have the right to provide feedback. Individuals may also believe that feedback will be disregarded by the

organization. Thus, in anticipation of individuals who are not comfortable with expressing or acting upon their own concerns, the organization should have both formal and informal procedures to solicit feedback.

Strategies for Implementation

The following are possible implementation strategies for creating conflict and grievance resolution processes that are culturally and linguistically appropriate:

- Provide cross-cultural communication training, including how to work with an interpreter, and conflict resolution training to staff who handle conflicts, complaints, and feedback.
- Provide notice in signage, translated materials, and other media about the right of each individual to provide feedback, including the right to file a complaint or grievance.
- Develop a clear process to address instances of conflict and grievance that includes follow-up and ensures that the individual is contacted with a resolution and next steps (QSource, 2005).
- Obtain feedback via focus groups, community council or town hall meetings, meetings with community leaders, suggestion and comment systems, open houses, and/or listening sessions.
- Hire patient advocates or ombudspersons (QSource, 2005).
- Include oversight of conflict and grievance resolution processes to ensure their cultural and linguistic appropriateness as part of the organization's overall quality assurance program.

Resources

Dator, J. (1991). *Culturally-appropriate dispute resolution techniques and the formal judicial system in Hawaii. A report to the State Justice Institute*. Retrieved from http://www.futures.hawaii.edu/publications/courts/CultApropAD1991.pdf

DuPraw, M., & Axner, M. (1997). *Working on common cross-cultural communication challenges*. Retrieved from http://www.pbs.org/ampu/crosscult.html

Lahey Clinic Foundation. (2012). Retrieved from http://www.lahey.org/

LeBaron, M. (1998). *Mediation and multicultural reality*. Retrieved from http://www.gmu.edu/programs/icar/pcs/lebaron.htm

Mind Tools. (n.d.). *Conflict resolution: Resolving conflict rationally and effectively.* Retrieved from http://www.mindtools.com/pages/article/newLDR_81.htm

National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center. (2004). *Bridging the cultural divide in health care setting: The essential role of cultural broker programs.* Retrieved from http://gucchd.georgetown.edu/products/CulturalBrokerGuide_English.pdf

Rogers, S., & Vilhena, B. (2005). Benchmarking patient complaints data across Ontario hospitals: University Health Network invites collaboration [Online case study]. *Healthcare Quarterly, 8,* 82–84. Retrieved from http://www.longwoods.com/product/download/code/17728

San Francisco Department of Public Health. (n.d.). Retrieved from http://www.sfdph.org/dph/default.asp

Townsend, J. R. (2011). Creating a culturally and politically appropriate dispute resolution model: Working in Indian country. *RCAC's Rural Review, 28*(3), 1–7. Retrieved from http://www.rcac.org/assets/white-papers/CreatingACulturally.pdf

University of Colorado Conflict Information Consortium. (n.d.). Retrieved from http://conflict.colorado.edu/

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012). *2011 national healthcare disparities report* (AHRQ Publication No. 12-0006). Retrieved from http://www.ahrq.gov/qual/measurix.htm#quality

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Standard 15: Communicate the Organization's Progress in Implementing and Sustaining CLAS

Standard 15

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Purpose

The purposes of communicating the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public are:

- To convey information to intended audiences about efforts and accomplishments in meeting the National CLAS Standards
- To learn from other organizations about new ideas and successful approaches to implementing the National CLAS Standards
- To build and sustain communication on CLAS priorities and foster trust between the community and the service setting
- To meet community benefits and other reporting requirements, including accountability for meeting health care objectives in addressing the needs of diverse individuals or groups

Components of the Standard

Communicate the organization's progress in implementing and sustaining CLAS

Communicating to all stakeholders, constituents, and the general public an organization's efforts to implement and sustain the National CLAS Standards can serve many purposes. Communication allows an organization to share its accomplishments in integrating

Terminology:

Please refer to the glossary in Appendix A for definitions of the key terms used.

culturally and linguistically appropriate services in accordance with the National CLAS Standards. It can also help institutionalize the National CLAS Standards by prompting the organization to regularly focus on the extent to which it has implemented each Standard, thereby helping to keep the organization accountable. Communicating the organization's progress also serves as a mechanism for organizations to learn from each other concerning new ideas and promising practices for implementing CLAS.

Organizations may exercise latitude in the information they make available and the means by which they report it to their stakeholders, constituents, and the general public. Examples of possible strategies are described in the following section. An organization that wishes to provide information can report one or more of the following: the results of organizational assessments (Standard 10), data collected and communities served (Standard 11), results of the assessments of the community health assets and needs (Standard 12), or the various partnerships that have been formed with other organizations from the community (Standard 13).

Being accountable to the public supports the continuous quality improvement process by documenting publicly the organization's ability to provide quality care and services in a culturally and linguistically appropriate manner. It also informs the organization and community of areas needing improvement. Communication about CLAS may serve to actively engage the community in assessing an organization's service, noting need for improvements, identifying programs that would match its needs, and charting related progress. Accountability is also important in situations in which an organization is using public funds to serve the community. Information provided to the public should be relevant, useful, and understandable to the community. An organization may also communicate CLAS implementation progress as part of its community benefits and other reporting or accountability requirements.

Strategies for Implementation

The following are implementation strategies for being accountable to the community by presenting to the public progress in implementing culturally and linguistically appropriate services.

Items on which to report may include (HHS OMH, 2001):

- Demographic data about the populations
- Utilization and availability statistics related to interpreters and translated materials

- Level of staff training in cultural and linguistic competency
- CLAS-related expenditures and cost-benefit data
- Assessment results based on activities suggested from Standard 10, community data collected in accordance with Standard 12, and the number of complaints and their resolution as collected pursuant to Standard 14
- Results from performance measures, satisfaction ratings, quality improvement and clinical outcome data analyses, and cost-effectiveness analyses

Strategies for presenting CLAS-related progress include:

- Draft and distribute materials that demonstrate efforts to be culturally and linguistically responsive (QSource, 2005). The materials should be easy to understand and in accordance with Standard 8.
- Partner with community organizations to lead discussions about the services provided and progress made (QSource, 2005); see also Standard 13.
- Create advisory boards to consult with community partners on issues affecting diverse populations and how best to serve and reach them (National Consensus Panel on Emergency Preparedness and Cultural Diversity, 2011).
- Engage community-based workers to help craft and deliver messages and implications of data. Community outreach that is culturally and linguistically tailored and provided by trusted messengers is central to ensuring messages are received, understood, and adhered to by local members of the community. Community-based workers are seen as trusted sources of health information and can help with reaching and educating communities (National Consensus Panel on Emergency Preparedness and Cultural Diversity, 2011).
- Convene educational forums. Agencies may consider partnering with well-respected and trusted community-based organizations to host regional educational forums, inviting local community representatives to participate. Educational forums are intended to provide education, materials, and information on topics of most concern to communities — whether regarding public health, public safety, or primary care. At the same time, they include feedback sessions, where community partners and representatives can assess and evaluate the validity and application of recommendations, resources, and materials to their communities' cultural, social, and economic circumstances (National Consensus Panel on Emergency Preparedness and Cultural Diversity, 2011).

Resources

Clinical and Translational Science Awards Consortium, Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. (2011). *Principles of community engagement* (2nd ed.) (National Institutes of Health Publication No. 11-7782). Retrieved from http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

National Committee for Quality Assurance. (2011). *Awards: Recognizing innovations in multicultural health care*. Retrieved from http://www.ncqa.org/tabid/453/Default.aspx

National Consensus Panel on Emergency Preparedness and Cultural Diversity. (2011). *Guidance for integrating culturally diverse communities into planning for and responding to emergencies: A toolkit. Recommendations of the National Consensus Panel on Emergency Preparedness and Cultural Diversity* (HHS Office of Minority Health Publication No. OMH-NHMA-5-10). Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/emergencypre/omh_diversitytoolkit.pdf

Ohmans, P., & Cushing, M. (2000). *Getting the word out: Effective health outreach to cultural communities*. Retrieved from The Medtronic Foundation website: http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf

Sandrick, K. (2006). Defining and measuring community benefit. *Trustee, 59*(9), 6–10. Retrieved from http://www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/PubsNewsArticleGen/data/2006October/0610TRU_CoverStory&domain=TRUSTEEMAG

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2001). *Cultural competence works: Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements*. Retrieved from ftp://ftp.hrsa.gov/financeMC/cultural-competence.pdf

Additional resources can be found in Appendix E and at www.ThinkCulturalHealth.hhs.gov.

Bibliography

National Consensus Panel on Emergency Preparedness and Cultural Diversity. (2011). *Guidance for integrating culturally diverse communities into planning for and responding to emergencies: A toolkit. Recommendations of the National Consensus Panel on Emergency Preparedness and Cultural Diversity* (HHS Office of Minority Health Publication No. OMH-NHMA-5-10). Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/emergencypre/omh_diversitytoolkit.pdf

QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips*. Retrieved from

http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Appendix A: Glossary

Acculturation:[1] The exchange of cultural features that results when groups of individuals having different cultures come into continuous firsthand contact; the original cultural patterns of either or both groups may be altered, but the groups remain distinct.

Augmentative and Alternative Communication (AAC) Resources:[2] Systems or devices that attempt to temporarily or permanently compensate for and facilitate the impairment and disability of individuals with severe expressive or language comprehension disorders. AAC may be required for individuals demonstrating impairments in gestural, spoken, and/or written modalities.

Auxiliary Aids and Services:[3] Devices or services that enable effective communication for people with disabilities. Examples include qualified interpreters, note takers, transcription services, written materials, assistive listening devices and systems, telephone communication devices for deaf persons, telephone handset amplifiers, video interpretive services, and open and closed captioning.

Bilingual:[4] A term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter but, by itself, does not ensure the ability to interpret.

Bisexual:[5] One whose sexual or romantic attractions and behaviors are directed at members of both sexes to a significant degree.

Caregiver:[6] An individual who assists another person who because of physical disability, chronic illness, or cognitive impairment is unable to perform certain activities on his/her own. So-called informal care can be offered by family members or friends, often in a home setting. Paid or volunteer professional care, or so-called formal care, can be obtained at home, in the community, or from institutions such as nursing facilities or government institutions.

Certification:[7] A process by which a certifying body (usually a governmental or professional organization) attests to an individual's qualifications to provide a particular service. Certification calls for formal assessment using an instrument that has been tested for validity and reliability so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job.

Certified Interpreter:[8] An interpreter who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training — or have only taken a screening test administered by an employing health, interpreter, or referral agency — are not considered certified.

Communication Needs:[9] Difficulty with some aspects of communicating. This difficulty may be minor and temporary or more complex and long term. The term "needs" refers both to the individual's needs and to what society can do to support the individual by examining the individual and the environments in which he/she interacts.

Requirements of the Americans with Disabilities Act communication needs extend beyond spoken language capability to include barriers imposed by disabilities affecting hearing, speech, and vision.[10]

Community Health Assessment/Community Health Needs Assessment (CHNA):[11] Community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.

Community Needs Assessment:[12] A community needs assessment identifies the strengths and resources available in the community to meet its needs. The assessment focuses on the capabilities of the community, including its citizens, agencies, and organizations. It provides a framework for developing and identifying services and solutions and building communities that support and nurture health and wellness.

A community needs assessment may be limited to a compilation of demographic data from census records, results of surveys conducted by others, and informal feedback from community partners. Alternatively, assessments may be expanded to include focus group discussions, town meetings, interviews with stakeholders, and telephone or mailed surveys to partnership members and the community.

Continuous Quality Improvement:[13] The complete process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions. It relies on an organizational and/or system culture that is proactive and supports continuous learning. Continuous quality improvement is firmly grounded in the overall mission, vision, and values of the agency/system. Perhaps most important, it is

dependent upon the active inclusion and participation of staff at all levels of the agency/system — children, youth, families, and stakeholders — throughout the process.

CLAS: See "Culturally and Linguistically Appropriate Services."

CLAS Standards: See "National CLAS Standards."

Cultural Broker:[14] Individuals from the community who serve as bridges between an organization and people of different cultural backgrounds.

Cultural and Linguistic Competency:[15] The capacity for individuals and organizations to work and communicate effectively in cross-cultural situations through the adoption and implementation of strategies to ensure appropriate awareness, attitudes, and actions and through the use of policies, structures, practices, procedures, and dedicated resources that support this capacity.

- ***Cultural Competency:*** A developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.
- ***Linguistic Competency:*** The capacity of individuals or institutions to communicate effectively at every point of contact. Effective communication includes the ability to convey information — both written and oral — in a manner that is easily understood by diverse groups, including persons of limited English proficiency, those who have low literacy skills or who are not literate, those having low health literacy, those with disabilities, and those who are deaf or hard of hearing.

Culturally and Linguistically Appropriate Services (CLAS):[16] Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.

Culture:[17,18] The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

Elements of culture include, but are not limited to, the following:

- Age
- Cognitive ability or limitations
- Country of origin
- Degree of acculturation
- Educational level attained
- Environment and surroundings
- Family and household composition
- Gender identity
- Generation
- Health practices, including use of traditional healer techniques such as Reiki and acupuncture.
- Linguistic characteristics, including language(s) spoken, written, or signed; dialects or regional variants; literacy levels; and other related communication needs.
- Military affiliation
- Occupational groups
- Perceptions of family and community
- Perceptions of health and well-being and related practices
- Perceptions/beliefs regarding diet and nutrition
- Physical ability or limitations
- Political beliefs
- Racial and ethnic groups include — but are not limited to — those defined by the U.S. Census Bureau.
- Religious and spiritual characteristics, including beliefs, practices, and support systems related to how an individual finds and defines meaning in his/her life.
- Residence (i.e., urban, rural, or suburban)
- Sex
- Sexual orientation

- Socioeconomic status

Determinants of Health:[19] Determinants of health care factors that influence health status and determine health differentials or health inequalities. They are many and varied and include, for example, natural biological factors, such as age, gender, and ethnicity; behavior and lifestyles, such as smoking, alcohol consumption, diet, and physical exercise; the physical and social environment, including housing quality, the workplace, and the wider urban and rural environment; and access to health care.

Effective Communication:[20] The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.

Ethnicity:[21] The Office of Management and Budget requires federal agencies to use a minimum of two ethnicities: Hispanic or Latino and Not Hispanic or Latino. Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Gay:[22] An attraction and/or behavior focused exclusively or mainly on members of the same sex or gender identity; a personal or social identity based on one's same-sex attractions and membership in a sexual-minority community.

Gender Expression:[23] Characteristics in appearance, personality, and behavior culturally defined as masculine or feminine.

Gender Identity:[24] One's basic sense of being a man, woman, or other gender.

Health:[25,26,27] Health encompasses many aspects, including physical, mental, social, and spiritual well-being. The World Health Organization also notes that health is "not merely the absence of disease or infirmity."

Health Care:[28] According to the Health Insurance Portability and Accountability Act of 1996, health care refers to the care, services, or supplies related to the health of an individual, including but not limited to, the following:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or a procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Disparities:[29] Differences in the receipt of, experiences with, and quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention.

Health Care Organization:[30] Any public or private institution involved in any aspect of delivering health care services.

Health Disparity:[31] A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socio-economic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Health Equity:[32,33] Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health Inequality:[34] Difference in health status or in the distribution of health determinants among different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates among people from different social classes. It is important to distinguish between a health inequality and a health inequity. Some health inequalities are attributable to biological variations or free choice, while others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case, it may

be impossible or ethically or ideologically unacceptable to change the health determinants, and so the resultant health inequality is unavoidable. In the second case, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair so that the resulting health inequalities also lead to an inequity in health.

Health Inequities:[35] Differences in health status or in the distribution of health determinants among different population groups.

Health Literacy:[36] The degree to which an individual has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health Numeracy:[37] The degree to which an individual has the capacity to access, process, interpret, communicate, and act on numerical, quantitative, graphical, biostatistical, and probabilistic health information needed to make effective health decisions.

Health Organization:[38] Any public or private institution addressing individual or community health and well-being.

Individuals and Groups:[39] Patients, clients, or consumers, including accompanying family members, guardians, or companions, seeking physical, mental, or other health-related services.

Interpreter:[40] An individual who renders a message spoken or signed in one language into a second language and who abides by a code of professional ethics.

Types of Interpreters:

- ***Ad Hoc Interpreter:***[41] An untrained individual who is called upon to interpret, such as a family member interpreting for his/her parents, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual in a hospital waiting room who volunteers to interpret. Also called a chance interpreter or lay interpreter.
- ***Bilingual Provider:***[42] An individual with proficiency in more than one language, enabling the person to provide services directly to limited English proficient patients in their non-English language.
- ***Bilingual Worker/Employee:***[43] An employee who is a proficient speaker of two languages and who may provide direct services in both languages but who, without additional training, is not qualified to serve as an interpreter.

- ***Dual-Role Interpreter:***[44] A bilingual employee in health care who has been tested for language skills and trained as a medical interpreter and who assumes the task of part-time medical interpreting willingly.
- ***Qualified Interpreter:***[45] An individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages, and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care.

Interpreting:[46]

- ***(noun)*** The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language, taking the cultural and social context into account. The purpose of interpreting is to enable communication between two or more individuals who do not speak one another's languages.
- ***(adjective)*** Concerning or involved with interpreting. Examples are interpreting services, interpreting issues.

Types of Interpreting:

- ***Community Interpreting:***[47] Interpreting that takes place in the course of communication in the local community among speakers of different languages. The community interpreter may or may not be a trained interpreter. Community settings include schools, social service agencies, clinics, legal services, and businesses that serve a diverse clientele.
- ***Consecutive Interpreting:***[48] A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce the original message, after the speaker or signer pauses, in a specific social context. Consecutive interpretation is likely to take longer than simultaneous, because the interpreter does not interpret while the speaker or signer is speaking or signing.
- ***Face-to-Face Interpreting:***[49] Interpreting in which the interpreter is present, in person, with both, or at least one, of the persons for whom interpreting is provided.
- ***First-Person Interpreting:***[50] The promotion by the interpreter of direct communication between the principal parties in the interaction through the use of direct utterances of each of the speakers, as though the interpreter were the voice of the person speaking, albeit in the language of the listener. For example, if the patient

says, "My stomach hurts," the interpreter says (in the second language), "My stomach hurts," not "She says her stomach hurts."

- ***Health Care Interpreting:***[51] Interpreting that takes place in health care settings of any sort, including doctors' offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations. Typically, the setting is an interview between a health care provider (doctor, nurse, lab technician) and a patient (or the patient and one or more family members).
- ***Simultaneous Interpretation:***[52] Highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce in real time a speaker or signer's message while the speaker or signer continues to speak or sign, in a specific social context.
- ***Telephone or Telephonic Interpreting:***[53] Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speakerphone or headsets. In health care settings, the principal parties, e.g., doctor and patient, are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone.
- ***Video Remote Interpreting (VRI):***[54] An interpreting service that uses video conference technology over dedicated lines or wireless technology offering a high-speed, wide-bandwidth video connection that delivers high-quality video images. To ensure that VRI is effective, the Department of Justice has established performance standards for VRI and requires training for users of the technology and other individuals involved with its use so that they may quickly and efficiently set up and operate the VRI system.

Language:[55] While the Office of Budget and Management has not established a list of language categories, the collection of language data has been pivotal in determining whether there has been discrimination by "national origin" under Title VI of the Civil Rights Act of 1964, and federal policies state that "reasonable steps" need to be taken so that persons of limited English proficiency can have "meaningful access" to programs or activities without charge for language services. Additionally, in 2000, the Department of Health and Human Services released its National Standards on Culturally and Linguistically Appropriate Services, which encourages all health care organizations and individual providers "to make their practices more culturally and linguistically accessible," including the use of race, ethnicity, and language data in program assessments and incorporation of these data into health records and organizational management systems.

Language Assistance Services:[56] Mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf or hard of hearing. These services can include in-person interpreters, bilingual staff, or remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation of written materials or signage, sign language, or braille materials.

Language Concordance:[57] Occurs when the individual seeking services or care and the provider of said services are able to speak the same primary language well.

Lesbian:[58] A woman who self-identifies as having an emotional, sexual, and/or relational attraction to other women.

Limited English Proficiency:[59,60] A concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without language assistance with respect to a particular type of service, benefit, or encounter.

Meaningful Access:[61] Recipients of federal financial assistance are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient (LEP) persons.

The HHS Office of Civil Rights Guidance explains that the obligation to provide meaningful access is fact dependent and starts with an individualized assessment that balances four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come into contact with the program; (3) the nature and importance of the program, activity, or service provided by the recipient to its beneficiaries; and (4) the resources available to the grantee/recipient and the costs of interpretation/translation services. There is no one-size-fits-all solution for Title VI compliance with respect to LEP persons, and what constitutes "reasonable steps" for large providers may not be reasonable where small providers are concerned.

National CLAS Standards:[62] The framework for culturally and linguistically appropriate services issued by the U.S. Department of Health and Human Services, Office of Minority Health. The National CLAS Standards are intended to inform, guide, and facilitate practices related to culturally and linguistically appropriate health service delivery.

Numeracy:[63] A part of literacy that implies a facility with basic probability and numerical concepts.

Plain Language:[64] A strategy for making written and oral information easier to understand; communication that users can understand the first time they read or hear it. A plain language document is one in which people can find what they need, understand what they find, and act appropriately on that understanding.

Primary Language:[65] The language that a limited English proficient individual identifies as the one that he/she uses to communicate effectively and would prefer to use to communicate with service providers.

Race:[66] The Department of Health and Human Services and its agencies follow the racial categories developed by the Office of Management and Budget and used by the U.S. census. These categories generally reflect a social definition of race recognized in this country and are not an attempt to define race biologically, anthropologically, or genetically. People may choose to report more than one race to indicate their racial mixture, such as "American Indian and White."

People who identify their origin as Hispanic, Latino, or Spanish may be of any race. Racial categories can include national origin or sociocultural groups.

Information on race is required for many federal programs and is important for making policy decisions, particularly for civil rights. States use these data to meet legislative redistricting principles. Race data also are used to promote equal employment opportunities and to assess environmental risks and racial disparities in health.

Reasonable Steps: For guidance on how to determine whether the steps taken to provide language access are "reasonable," providers or organizations should refer to the Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.

Sex:[67] The Department of Health and Human Services and its agencies follow the sex categories developed by the Office of Management and Budget and used by the U.S. census. The census operationalizes sex as "male" or "female." The census question regarding sex remains unchanged from the previous census. Information on the sex of individuals is one of the few items obtained in the original 1790 census and in every census since.

It is important to note that sex differs from the concepts of gender, gender identity, and gender expression.

Sexual Identity:[68] Encompasses attraction, behavior, and identity. Most researchers studying sexual orientation have defined it operationally in terms of one or more of the following components. Defined in terms of *behavior*, sexual orientation refers to an enduring pattern of sexual or romantic activity with men, women, or both sexes. Defined in terms of *attraction* (or desire), it denotes an enduring pattern of experiencing sexual or romantic feelings for men, women, or both sexes. Identity encompasses both personal identity and social identity. Defined in terms of *personal identity*, sexual orientation refers to a conception of the self-based on one's enduring pattern of sexual and romantic attractions and behaviors toward men, women, or both sexes. Defined in terms of *social* (or collective) *identity*, it refers to a sense of membership in a social group based on a shared sexual orientation and a linkage of one's self-esteem to that group.

Social Determinants of Health:[69] The conditions in which people are born, grow, live, work, and age, including the health system.

Staff:[70] The group of individuals formally affiliated with an institution, including paid employees, contractors, and unpaid volunteers.

Threshold Population:[71] A threshold population is a linguistic group that makes up 15% or more of a program's clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients, and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program, and Haitian-Creole would be considered a threshold language. Some programs may target multiple groups and, therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.

Traditional Healer Services:[72] The application of knowledge, skills, and practices based on the experiences indigenous to different cultures. These services are directed towards the maintenance of health, as well as the prevention, diagnosis, and improvement of physical and mental illness. Examples of traditional healers include herbalists, faith healers, and practitioners of Chinese or Ayurvedic medicine. In contrast, allopathic service providers are those trained in western medicine.

Transgender:[73] A person whose gender identity and/or expression is different from that typically associated with their assigned sex at birth.

Translation:[74] The conversion of a written text into a corresponding written text in a different language.

Translator:[75] A person who translates written texts.

TTY:[76] TTY stands for text telephone. It is also sometimes called a TDD, or telecommunication device for the deaf. TTY is the more widely accepted term, however, as TTYs are used by many people, not just people who are deaf.

Vital Documents:[77] For the purposes of ensuring language access, vital documents are written documents that are "vital" to programs or limited English proficient populations. Examples include signs, directions, and notices about the availability of interpreter services, client intake forms, and legal documents (e.g., consent forms, notices of client rights and responsibilities, privacy notices, complaint forms, grievance policies).

Bibliography

[1] Kottak, C. P. (2007). *Windows on humanity* (3rd ed.). New York: McGraw Hill.

[2] The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

[3] The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

[4] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms*. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[5] Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

[6] Day, T. (n.d.). *About caregiving*. Retrieved from http://www.longtermcarelink.net/eldercare/caregiving.htm

[7] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms*. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[8] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms*. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[9] Talking point: The first step for information on children's communication. (2010). Speech, language and communication needs. In *Glossary*. Retrieved from http://www.communicationhelppoint.org.uk/da/Glossary.aspx

[10] Institute of Medicine. (2009). Defining language need and categories for collection. In *Race, ethnicity, and language data: Standardization for health care quality improvement* (pp. 93–126). Retrieved from http://www.nap.edu/openbook.php?record_id=12696&page=93

[11] Consensus Statement from American Public Health Association (APHA), Association of Schools of Public Health (ASPH), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), National Network of Public Health Institutes (NNPHI), and Public Health Foundation (PHF). (2012). Maximizing the Community Health Impact of Community Health Needs Assessments Conducted by Tax-exempt Hospitals http://www.naccho.org/topics/infrastructure/mapp/loader.cfm?csModule=security/getfile&pageID=228911

[12] U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.). *Community needs assessment*. Retrieved from http://www.childwelfare.gov/systemwide/assessment/community.cfm

[13] National Child Welfare Resource Center for Organizational Improvement & Casey Family Programs. (2005). *Using continuous quality improvement to improve child welfare practice*. Retrieved from http://muskie.usm.maine.edu/helpkids/rcpdfs/CQIFramework.pdf

[14] Massachusetts Department of Public Health, Office of Health Equity. (2009). *Making CLAS happen: Six areas for action*. Retrieved from http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/health-equity/clas/making-clas-happen.html

[15] Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care volume I: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Georgetown University Child Development Center, Child and Adolescent Service System Program Technical Assistance Center.

[16] U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[17] Gilbert, J., Goode, T. D., & Dunne, C. (2007). Cultural awareness. In *Curricula enhancement module series*. Retrieved from the National Center for Cultural Competence website: http://www.nccccurricula.info/awareness/index.html

[18] U.S. Department of Health and Human Services, Office of Minority Health. (2005). *What is cultural competency?* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

[19] World Health Organization. (2012). *Health impact assessment: Glossary of terms used, A–E*. Retrieved from http://www.who.int/hia/about/glos/en/index.html

[20] The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

[21] Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011, March). *Overview of race and Hispanic origin: 2010. 2010 Census Briefs*. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

[22] Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

[23] Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

[24] Bockting, W. O. (1999). *From construction to context: Gender through the eyes of the transgendered*. SIECUS Report 1(Oct./Nov.):3–7.

[25] U.S. Department of Health and Human Services, Indian Health Services. (n.d.). *Our mission*. Retrieved from http://www.ihs.gov/index.cfm?module=ihsIntro

[26] U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 National strategy for suicide prevention: Goals and objectives for action*. Retrieved from http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

[27] World Health Organization. (1946). *Definition of health in preamble to the constitution of the World Health Organization*. Geneva, Switzerland: World Health Organization.

[28] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 102-168, § 160.103, 110 Stat. 1936 (1996)

[29] Institute of Medicine (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1

[30] U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[31] U.S. Department of Health and Human Services, Office of Minority Health, National Partnership for Action to End Health Disparities. (2011). *Health equity & disparities.* Retrieved from http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34

[32] U.S. Department of Health and Human Services, Office of Minority Health, National Partnership for Action to End Health Disparities. (2011). *Health equity & disparities.* Retrieved from http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34

[33] Braveman, P. A. (2003). Monitoring equity in health and healthcare: A conceptual framework. *Journal of Health, Population, and Nutrition, 21,* 181–192.

[34] World Health Organization. (2012). *Health impact assessment: Glossary of terms used, F–P.* Retrieved from http://www.who.int/hia/about/glos/en/index1.html

[35] World Health Organization. (2012). *Health impact assessment: Glossary of terms used, F–P.* Retrieved from http://www.who.int/hia/about/glos/en/index1.html

[36] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2000). Health communication and health IT. In *Healthy people 2010*. Retrieved from http://www.healthypeople.gov/2010/hp2020/Objectives/TopicArea.aspx?id=25&TopicArea=Health+Communication+and+Health+IT

[37] Golbeck, A. L., Ahlers-Schmidt, C. R., Paschal, A. M., & Dismuke, M. C. (2005). A definition and operational framework for health numeracy. *American Journal of Preventive Medicine, 29,* 375–376. doi:10.1016/j.amepre.2005.06.012

[38] U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[39] U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[40] National Health Law Program (2010). *What's in a word? A guide to understanding interpreting and translation in health care*. Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf

[41] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[42] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[43] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms*. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[44] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[45] National Health Law Program (2010). *What's in a word? A guide to understanding interpreting and translation in health care*. Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf

[46] National Health Law Program (2010). *What's in a word? A guide to understanding interpreting and translation in health care*. Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf

[47] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[48] ASTM, International. (2007). *Standard guide for language interpretation services*. doi:10.1520/F2089-01R07

[49] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[50] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[51] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms*. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[52] ASTM, International. (2007). *Standard guide for language interpretation services*. doi:10.1520/F2089-01R07

[53] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[54] U.S. Department of Justice. (2011). *Highlights of the final rule to amend the Department of Justice's regulation implementing Title II of the ADA* [Fact sheet]. Retrieved from http://www.ada.gov/regs2010/factsheets/title2_factsheet.html

[55] Institute of Medicine. (2009). *Race, ethnicity, and language data: Standardization for health care quality improvement*. Retrieved from http://iom.edu/Reports/2009/RaceEthnicityData.aspx

[56] The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

[57] Institute of Medicine. (2009). Defining language need and categories for collection. In *Race, ethnicity, and language data: Standardization for health care quality improvement* (pp. 93–126). Retrieved from http://www.nap.edu/openbook.php?record_id=12696&page=93

[58] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). *Top Health Issues for LGBT Populations Information & Resource Kit.* (HHS Publication No. (SMA) 12-4684). Retrieved from http://store.samhsa.gov/shin/content/SMA12-4684/SMA12-4684.pdf

[59] The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

[60] U.S. Department of Health and Human Services, Office for Civil Rights. (2004). Limited English proficiency (LEP). Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html

[61] U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons: Summary*. Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html

[62] U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[63] Schwartz, L. M., Woloshin, S., Black, W. C., & Welch, H. G. (1997). The role of numeracy in understanding the benefit of screening mammography. *Annals of Internal Medicine, 127,* 966–972.

[64] Plain Language Action and Information Network. (n.d.). *What is plain language?* Retrieved from http://www.plainlanguage.gov/whatisPL/index.cfm

[65] U.S. Department of Health and Human Services. (2008). *Hawaii Department of Human Services Resolution Agreement.* Retrieved from http://www.hhs.gov/ocr/civilrights/activities/agreements/hawaiiagree.html

[66] U.S. Department of Commerce, Census Bureau. (2011). *Overview of race and Hispanic origin: 2010.* Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

[67] U.S. Department of Commerce, Census Bureau. (2011, May). *Age and sex composition, 2010* [2010 Census Brief No. C2010BR-03]. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

[68] Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

[69] World Health Organization. (2012). *Social determinants of health.* Retrieved from http://www.who.int/social_determinants/en

[70] U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[71] Massachusetts Department of Public Health, Office of Health Equity. (2009). Glossary and list of acronyms. In *Making CLAS happen: Six areas for action* (pp. 171–183). Retrieved from http://www.mass.gov/eohhs/docs/dph/health-equity/clas-appendices-glossary.pdf

[72] The World Bank. (2011). *Traditional healer services*. Retrieved from http://go.worldbank.org/433PVWTQL0

[73] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). *Top Health Issues for LGBT Populations Information & Resource Kit.* (HHS Publication No. (SMA) 12-4684). Retrieved from http://store.samhsa.gov/shin/content/SMA12-4684/SMA12-4684.pdf

[74] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[75] National Council on Interpreting in Health Care. (2008). *The terminology of health care interpreting: A glossary of terms.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

[76] AboutTTY.com: The power of connecting. (n.d.). *What is a TTY?* Retrieved from http://www.abouttty.com

[77] Massachusetts Department of Public Health, Office of Health Equity. (2009). Glossary and list of acronyms. In *Making CLAS happen: Six areas for action* (pp. 171–183). Retrieved from http://www.mass.gov/eohhs/docs/dph/health-equity/clas-appendices-glossary.pdf

Appendix B: National CLAS Standards Enhancement Initiative

Background

In 2000, the Office of Minority Health at the U.S. Department of Health and Human Services published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, known as the National CLAS Standards. The development process began in 1999, when the Office of Minority Health convened key stakeholders to begin crafting a set of national standards that would guide the care provided to the nation's culturally and linguistically diverse populations. Published in 2000, the *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report* resulted from extensive research, discussions, and input from thousands of citizens. The original National CLAS Standards provided a common understanding and guidance regarding cultural and linguistic competency, with the ultimate goal of reducing racial and ethnic health disparities.

The original National CLAS Standards, the first of their kind, have served as catalyst and conduit for efforts to improve quality of care and achieve health equity over the past 10 years. In recognition of those vast changes, the Office of Minority Health undertook the National CLAS Standards Enhancement Initiative from 2010 to 2012. Although much progress has been made toward universal implementation of culturally and linguistically appropriate services, there is still much work to be done. The enhanced National CLAS Standards seek to set a new bar for culturally and linguistically appropriate services to improve the health of our ever-diversifying communities.

Goals

- To examine the National CLAS Standards, originally promulgated in 2000, for their relevance and applicability to the 21st century
- To have the enhanced National CLAS Standards serve as the cornerstone for culturally and linguistically appropriate services in the United States
- To launch new and innovative promotion and marketing initiatives for the National CLAS Standards

- To coordinate the National CLAS Standards Enhancement Initiative with the Affordable Care Act and other cultural and linguistic competency standards (e.g., The Joint Commission, National Committee for Quality Assurance)
- To address the following areas throughout the enhancement initiative process:
    - *Increase awareness regarding the importance and influence of cultural and linguistic competency*
    - *Increase impact of National CLAS Standards by expanding scope, audience, and inclusivity*
    - *Ensure the National CLAS Standards converge with the organization's quality improvement efforts*
    - *Assist in the implementation of the Standards through additional resources*
    - *Incorporate health literacy*
    - *Promote the importance of research regarding the efficacy of the Standards*
    - *Address advancements and developments in the field, including health care reform*
- To promulgate an enhanced version of the National CLAS Standards

Development Process

Discussions began in 2009 at the HHS Office of Minority Health regarding a plan to enhance the National CLAS Standards. The National CLAS Standards Enhancement Initiative formally began in 2010 following the same development process as the original National CLAS Standards project in 1999–2001. The development process had three major components: public comment, the Advisory Committee, and a systematic literature review.

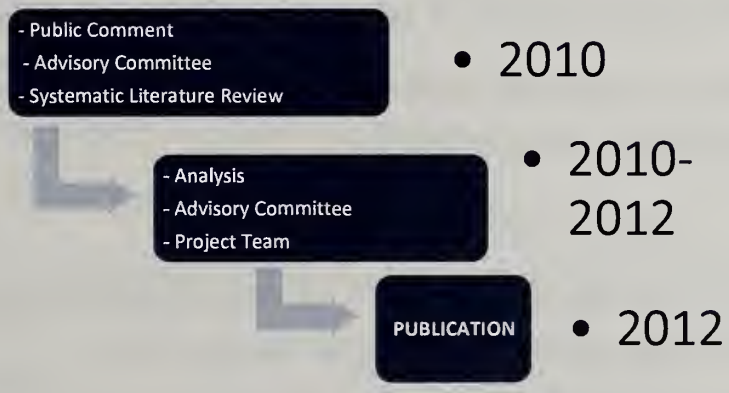

Figure 4: Phases of the National CLAS Standards Enhancement Initiative

- ***Public Comment:*** Three regional public meetings were held in fall 2010 in the same locations as in the 2001 National CLAS Standards' development: Baltimore, MD;

Chicago, IL; and San Francisco, CA. Public comment was also collected via written and online submissions during the same time period. A public comment meeting report and a public comment online and written submissions report are available online at www.ThinkCulturalHealth.hhs.gov.

- ***National Project Advisory Committee:*** A National Project Advisory Committee was convened in 2010 and provided input and review throughout the development process, including several in-person and virtual meetings. Members of the Advisory Committee represent the public, private, and government sectors. It includes stakeholders representing a variety of health settings, such as managed care, community health centers, insurance providers, local and state health departments, community- and faith-based organizations, and federal government officials.
- ***Systematic Literature Review:*** A systematic literature review was developed in 2010 to use as foundational knowledge for the Enhancement Initiative. This report provided a synthesis of accomplishments, advances, and promising practices in the field since the publication of the National CLAS Standards in 2000.

Public Comment

Public comment was collected in fall 2010 through meetings across the country, an online submission portal, and written submissions. The announcement of the public comment opportunities appeared in the Federal Register published on Sept. 23, 2010.

Public Comment Meetings

Three public comment meetings were held:

- Baltimore, MD; Oct. 22, 2010
- San Francisco, CA; Nov. 4, 2010
- Chicago, IL; Nov. 15, 2010

The public comment meeting report and the public comment online and written submissions report are available online at www.ThinkCulturalHealth.hhs.gov.

Each public comment meeting gathered detailed input from individuals and organizations. It included open-microphone public comment and small group discussions with guided questions and group feedback. The following themes arose from the comments heard across the three meetings.

The enhanced National CLAS Standards should:

- Encompass a broad definition of culture to include religion and spirituality; the lesbian, gay, bisexual, and transgender community; deaf and hard of hearing individuals; and individuals with limited vision
- Incorporate the areas of patient satisfaction and safety
- Address issues of health literacy
- Establish congruency with other standards in the field
- Be action oriented
- Reflect advancements in terminology, technology, and more, including medical homes, electronic health records, and language access

Written and Online Public Comment

Written and online public comment was collected from Sept. 20, 2010, to Dec. 31, 2010. The following overarching themes emerged:

The National CLAS Standards should:

- Expand the target audience beyond health care organizations
- Encompass a broad definition of culture to include religion and spirituality; the lesbian, gay, bisexual, and transgender community; hard of hearing and deaf individuals; and individuals with limited vision
- Offer more guidance within the Standards pertaining to language assistance services
- Establish congruency with other Standards in the field

National Project Advisory Committee

The National CLAS Standards Enhancement Initiative's National Project Advisory Committee comprises 36 experts in the fields of cultural and linguistic competency representing HHS agencies, academic institutions, health associations, and other not-for-profit organizations. The Advisory Committee provided insight, recommendations, and

Advisory Committee Meetings

Advisory Committee Meetings Held During the Enhancement Initiative

October 2010: Kick-Off Webinar
January 2011: Three-Day Working Meeting
Summer 2011: Four Working Webinar Discussions
December 2011: Three-Day Working Meeting

Figure 5: Advisory Committee Meetings

review throughout the development of the enhanced Standards and the Blueprint. The Enhancement Initiative Project Team[2] convened several meetings with the Advisory Committee throughout the Enhancement Initiative, either in person or virtually (see Figure 5).

The Project Team conducted informal interviews in fall 2010 with the members of the Advisory Committee in order to gather input on the National CLAS Standards from subject matter experts representing a myriad of roles in the field of cultural and linguistic competency. These conversations, along with the public comment and the systematic literature review, served to begin the laying of the foundation for the enhanced National CLAS Standards in fall 2010. The topics of discussion included the purpose and scope of the future National CLAS Standards, the target audience, and issues surrounding implementation and promotion.

At the January 2011 meeting, the Advisory Committee discussed the following topics in depth:

- Purpose
- Definitions
- Inclusivity
- Audience
- Health Literacy
- Language Access Services
- Measurements
- Implementation
- Promotion
- End Product

The January 2011 meeting built the framework for the project team to begin drafting the enhanced National CLAS Standards. During spring 2011, the Advisory Committee reviewed and provided feedback on a document of terminology and definitions that would serve as the conceptual underpinning of the enhanced National CLAS Standards. The Advisory Committee met virtually for a series of webinars in summer 2011 to define the direction of the enhanced National CLAS Standards and discuss draft Standards. In addition, the committee members began compiling information and materials for the guidance document to accompany the enhanced National CLAS Standards.

The Advisory Committee Interview Report, January 2011 Meeting Report, and December 2011 Meeting Report are available online at www.ThinkCulturalHealth.hhs.gov

[2] The Enhancement Initiative Project Team was managed by an outside contractor. Team members are identified in Appendix C.

The Advisory Committee provided in-depth reviews of the enhanced Standards' drafts in late summer and fall 2011. It also reviewed a draft of this guidance document to be published with the National CLAS Standards. The Advisory Committee met in December 2011 to finalize the National CLAS Standards and its report and make plans for the next steps.

Systematic Literature Review

The Environmental Scan is available online at www.ThinkCulturalHealth.hhs.gov

The systematic literature review, developed in 2010, discusses the evolution of the efforts to improve cultural and linguistic appropriateness since the release of the National CLAS Standards in 2000. It addresses the broad dissemination, promotion, and implementation nationwide of the National CLAS Standards and the concepts of CLAS. In addition, the report covers cultural competency education initiatives; adoption of CLAS at the federal, state, and organizational levels; changes in accreditation standards to explicitly include CLAS; the proliferation of technical assistance regarding CLAS; and research and evaluation of the National CLAS Standards' impact. The report concludes with areas for consideration that emerged from the literature and research of the last 10 years, which provided insight into the issues the enhanced National CLAS Standards should address.

Appendix C: National Project Advisory Committee

Affiliations listed for identification purposes only; no endorsement of this report by Advisory Committee members or their employers should be inferred.

Wilma Alvarado-Little, M.A., M.S.W.
Albany, New York
Chair of the Policy and Research Committee,
National Council on Interpreting in Health Care
Director of the Community Engagement/ Outreach
Core, Center for the Elimination of Minority Health
Disparities at the University of Albany,
State University of New York

Dennis Andrulis, Ph.D., M.P.H.
Austin, Texas
Associate Professor, University of Texas School of
Public Health
Senior Research Scientist, Texas Health Institute

Frances E. Ashe-Goins, R.N., M.P.H.
Washington, District of Columbia
Deputy Director
Office on Women's Health
U.S. Department of Health and Human Services

George Askew, M.D.
Washington, District of Columbia
Chief Medical Officer
Administration for Children and Families
U.S. Department of Health and Human Services

Arlene Austin
Baltimore, Maryland
Director
Office of Equal Opportunity and Civil Rights
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Charlene Avery, M.D.
Rockville, Maryland
Director
Office of Clinical and Preventive Services
Indian Health Service
U.S. Department of Health and Human Services

Lynne Bergero, M.H.S.A.
Oakbrook Terrace, Illinois
Project Director in the Division of Healthcare
Quality Evaluation, The Joint Commission

Cindy Brach, M.P.P.
Rockville, Maryland
Senior Health Policy Researcher
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

Jessica Briefer French, M.H.S.A.
Washington, District of Columbia
Senior Consultant for Research, National
Committee for Quality Assurance

Jeffrey Caballero, M.P.H.
Oakland, California
Executive Director, Association of Asian Pacific
Community Health Organizations

Carol Crecy
Washington, District of Columbia
Aging Program Specialist
Administration for Community Living
U.S. Department of Health and Human Services

Linda Cummings, Ph.D.
Washington, District of Columbia
Vice President, National Association of Public
Hospitals and Health Systems
Director, The National Public Health and Hospital
Institute

Irene Dankwa-Mullan, M.D., M.P.H.
Bethesda, Maryland
Medical Officer
Division of Scientific Programs
National Institutes of Health
U.S. Department of Health and Human Services

Kim Drumgo
Durham, North Carolina
Chief Diversity Official, Blue Cross Blue Shield of North Carolina

Willarda V. Edwards, M.D., M.B.A.
Baltimore, Maryland
Past President, National Medical Association

Leonard Epstein, MSW
Rockville, Maryland
Senior Advisor
Clinical Quality and Culture
Health Resources and Services Administration
U.S. Department of Health and Human Services

Ron Finch, Ed.D.
Washington, District of Columbia
Vice President, National Business Group on Health

Iris Garcia-Caban, Ph.D.
Quincy, Massachusetts
Performance Improvement Policy Analyst, Massachusetts Executive Office of Health and Human Services Medicaid Program

Rose Gonzalez, Ph.D., M.P.S., R.N.
Silver Spring, Maryland
Director of Government Affairs, American Nurses Association

Tawara Goode, M.A.
Washington, District of Columbia
Assistant Professor & Director, National Center for Cultural Competence, Georgetown University

Fred Hobby, M.A., CDM
Chicago, Illinois
President and CEO, Institute For Diversity in Health Management of the American Hospital Association

Roslyn Holliday Moore
Rockville, Maryland
Senior Advisor
Office of Behavioral Health Equity
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Sonja Hutchins, M.D., M.P.H., Dr. P.H.
Atlanta, Georgia
Senior Medical Epidemiologist
Office of Minority Health and Health Equity
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services

Thomas LaVeist, Ph.D.
Baltimore, Maryland
Director, Center for Health Disparities Solutions, Johns Hopkins University

Heather R. Lawson, J.D., M.P.H.
Washington, District of Columbia
Civil Rights Analyst
Office for Civil Rights
U.S. Department of Health and Human Services

Robert C. Like, M.D., M.S.
New Brunswick, New Jersey
Professor and Director, Center for Healthy Families and Cultural Diversity, Department of Family Medicine and Community Health, University of Medicine and Dentistry of New Jersey – Robert Wood Johnson Medical School

Francis G. Lu, M.D.
Sacramento, California
Luke & Grace Kim Professor in Cultural Psychiatry and Director of Cultural Psychiatry, Department of Psychiatry & Behavioral Sciences, University of California, Davis

Luben Montoya, J.D., M.P.A.
Washington, D.C.
Supervisory Civil Rights Analyst
Office for Civil Rights
U.S. Department of Health and Human Services

Carmen Nevarez, M.D., M.P.H.
Oakland, California
Vice President of External Relations and Preventive Medicine Advisor, Public Health Institute

Guadalupe Pacheco, M.S.W.
Rockville, Maryland
Senior Health Advisor to the Director
Office of Minority Health
U.S. Department of Health and Human Services

Elena Rios, M.D., M.S.P.H.
Washington, District of Columbia
President & CEO, National Hispanic Medical Association

Susan Matsuko Shinagawa
Spring Valley, California
Co-Founder & Past Chair, Asian and Pacific Islander National Cancer Survivors Network, Asian & Pacific Islander American Health Forum
Past Chair, Intercultural Cancer Council

Lisa Strumwasser
Washington, District of Columbia
Special Assistant
Office of the Assistant Secretary for Legislation
U.S. Department of Health and Human Services

Ileen Sylvester, M.B.A.
Anchorage, Alaska
Vice President of Executive and Tribal Services, Southcentral Foundation

Gayle Tang, M.S.N., R.N.
Oakland, California
Senior Director, National Linguistic and Diversity Infrastructure Management
Kaiser Permanente, National Diversity

Ho Tran, M.D., M.P.H.
San Francisco, California
President and CEO, National Council of Asian and Pacific Islander Physicians

Matthew K. Wynia, M.D., M.P.H., FACP
Chicago, Illinois
Director of The Institute for Ethics and The Center for Patient Safety, American Medical Association

Mara Youdelman, J.D., LLM
Washington, District of Columbia
Chair, Certificate Commission for Healthcare Interpreters
Senior Attorney, National Health Law Program

Enhancement Initiative Project Team

C. Godfrey Jacobs
Project Manager
SRA International, Inc.

Darci L. Graves, M.P.P., M.A., M.A.
Senior Health Education & Policy Specialist
SRA International, Inc.

Jennifer Kenyon
Senior Research Associate
SRA International, Inc.

Crystal L. Barksdale, Ph.D.
Senior Research Analyst
SRA International, Inc.

Appendix D: Crosswalk — National CLAS Standards 2000 and 2012

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

National CLAS Standards: 2000		National CLAS Standards: 2012	
		The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:	
Theme 1: Culturally Competent Care		**Principal Standard**	
1.	Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.	**1.**	Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
		Theme 1: Governance, Leadership, and Workforce	
		2.	Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
2.	Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.	**3.**	Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

National CLAS Standards: 2000		National CLAS Standards: 2012	
3.	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.	**4.**	Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
Theme 2: Language Access Services		**Theme 2: Communication and Language Assistance**	
4.	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	**5.**	Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
5.	Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	**6.**	Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
6.	Health care organizations must ensure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	**7.**	Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
7.	Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	**8.**	Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

National CLAS Standards: 2000		National CLAS Standards: 2012	
Theme 3: Organizational Supports		**Theme 3: Engagement, Continuous Improvement, and Accountability**	
8.	Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	**9.**	Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.
9.	Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.	**10.**	Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
10.	Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.	**11.**	Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
11.	Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.	**12.**	Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

National CLAS Standards: 2000		National CLAS Standards: 2012	
12.	Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.	**13.**	Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
13.	Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.	**14.**	Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
14.	Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS Standards and to provide public notice in their communities about the availability of this information.	**15.**	Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Appendix E: Resources

Appendix E provides an expanded list of resources, organized by the National CLAS Standards' themes, that pertain to advancing and sustaining CLAS policy and practice. The table below provides an overview of the Standards and the themes in which they are found.

Theme	Standards
Principal Standard	• Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Theme 1: Governance, Leadership, and Workforce	• Advance and sustain governance and leadership that promotes CLAS and health equity • Recruit, promote, and support a diverse governance, leadership, and workforce • Educate and train governance, leadership, and workforce in CLAS
Theme 2: Communication and Language Assistance	• Offer communication and language assistance • Inform individuals of the availability of language assistance • Ensure the competence of individuals providing language assistance • Provide easy-to-understand materials and signage
Theme 3: Engagement, Continuous Improvement, and Accountability	• Infuse CLAS throughout the organization's planning and operations • Conduct organizational assessments • Collect and maintain demographic data • Conduct assessments of community health assets and needs • Partner with the community • Create conflict and grievance resolution processes • Communicate the organization's progress regarding CLAS

Principal Standard Resources
Adelman, L. (Creator, Producer). (2008). *Unnatural causes: Is inequality making us sick?* [Documentary series]. United States: California Newsreel with Vital Pictures.
Advisory Commission on Consumer Protection and Quality in the Health Care Industry. (1997). *Consumer bill of rights and responsibilities: Report to the President of the United States.* Retrieved from http://www.opm.gov/insure/archive/health/cbrr.htm
American Association on Intellectual and Developmental Disabilities. (n.d.). *Definition of intellectual disability.* Retrieved from http://www.aaidd.org/content_100.cfm?navID=21
American Medical Association. (2006). Content area 4. Develop workforce. In *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations* (pp. 47–54). Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf
American Medical Association. (2006). Content area 5a. Socio-cultural context. In *Improving communication, improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations* (pp. 61–65). Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf
Beach, M. C., Saha, S., & Cooper, L. A. (2006). *The role and relationship of cultural competence and patient-centeredness in health care quality.* Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Oct/The%20Role%20and%20Relationship%20of%20Cultural%20Competence%20and%20Patient%20Centeredness%20in%20Health%20Care%20Quality/Beach_rolerelationshipcultcomppatient%20cent_960%20pdf.pdf
Bobal, A. M., Brown, H. L., Hartman, T. L., Magee, M., & Schmidt, C. M. (2007). Navigating the US health care system: A video guide for immigrant and diverse patient populations. *Journal of the Medical Library Association, 95*(3), 286–289. doi:10.3163/1536-5050.95.3.286
Brach C., Keller, D, Hernandez, L., Baur, C., Parker, R., Schyve, P., Lemerise, & Schillinger, D. (2012). Ten Attributes of Health Literate Health Care Organizations. Washington DC. Retrieved from: http://www.iom.edu/Activities/PublicHealth/HealthLiteracy.aspx
Briefer French, J., Schiff, D., Han, E., & Weinick, R. (2008). *Multicultural health care: A quality improvement guide.* Retrieved from National Committee for Quality Assurance website: http://www.ncqa.org/portals/0/hedisqm/clas/clas_toolkit.pdf
California Pan-Ethnic Health Network. (2010). *Building quality & equitable health care systems.* (Conference report). Retrieved from http://www.cpehn.org/pdfs/Building%20Quality%20and%20Equitable%20Health%20Care%20Systems%2010-10.pdf
DeafMD.org. (2012). Retrieved from http://www.deafmd.org

Principal Standard Resources
DiversityRx. (2012). Retrieved from http://www.diversityrx.org/
EthnoMed. (2012). Retrieved from http://ethnomed.org/
Frampton, S., Guastello, S., Brady, C., Hale, M., Smith, S. B., & Stone, S. (n.d.). *Patient-centered care: Improvement guide.* Retrieved from http://www.patient-centeredcare.org/index.html
Galanti, G. A. (2008). *Caring for patients from different cultures: Case studies from American hospitals* (4th ed.). Philadelphia, PA: University of Pennsylvania Press.
Gallaudet University, Laurent Clerc National Deaf Education Center. (2008). *Healthcare for deaf and hard of hearing patients: Clinics and special services.* Retrieved from http://www.gallaudet.edu/clerc_center/information_and_resources/info_to_go/educate_children_(3_to_21)/social-emotional_development/mental_health_and_wellness/hlthcare_delivery_for_dhoh_patients_clinicsspec_svcs.html
Gay and Lesbian Medical Association. (2001). *Healthy people 2010 companion document for lesbian, gay, bisexual and transgender (LGBT) health.* Retrieved from http://www.nalgap.org/PDF/Resources/HP2010CDLGBTHealth.pdf
Gay and Lesbian Medical Association. (n.d.). Retrieved from http://www.glma.org/
The George Washington Institute for Spirituality and Health. (n.d.). Retrieved from http://www.gwish.org/
Goldney, R. D., Fisher, L. I., & Wilson, D. H. (2001). Mental health literacy: An impediment to the optimum treatment of major depression in the community. *Journal of Affective Disorders, 64*(2–3), 277–84.
Harmer, L. (1999). Health care delivery and deaf people: Practice, problems, and recommendations for change. *Journal of Deaf Studies and Deaf Education, 4*(2), 73–110. doi:10.1093/deafed/4.2.73
Health Research & Educational Trust, Institute for Diversity in Health Management (2011). *Building a culturally competent organization: The quest for equity in health care.* Retrieved from http://www.hret.org/quality/projects/resources/cultural-competency.pdf
HealthCare Chaplaincy. (2009). *Cultural and spiritual sensitivity: A learning module for health care professionals.* Retrieved from http://www.healthcarechaplaincy.org/userimages/A Dictionary of Patients' Spiritual Cultural Values for Health Care Professionals July 2011.pdf
HealthCare Chaplaincy. (2011). *A dictionary of patients' spiritual & cultural values for health care professionals.* Retrieved from http://www.healthcarechaplaincy.org/userimages/doc/A-Dictionary-of-Patients'-Spiritual-Cultural-Values-for-Health-Care-Professionals.pdf

Principal Standard Resources
Hearing Loss Association of America. (2012). Retrieved from http://www.hearingloss.org/
Herndon, J., Chaney, M., & Carden, D. (2011). Health literacy and emergency department outcomes: A systematic review. *Annals of Emergency Medicine, 57*(4), 334–345. doi:10.1016/j.annemergmed.2010.08.035.
Institute for Patient- and Family-Centered Care. (2012). Retrieved from http://www.ipfcc.org
Institute of Medicine, Committee on Future Directions for the National Healthcare Quality and Disparities Reports. (2010). *Future directions for the national healthcare quality and disparities reports.* Retrieved from http://www.ahrq.gov/research/iomqrdrreport/iomqrdrreport.pdf
International Medical Interpreters Association. (2012). *National interpreter advocacy forum.* Retrieved from http://www.imiaweb.org/advocacy/NatIntAdvForum.asp
International Society for Urban Health. (2005). Retrieved from http://www.isuh.org/
Johns Hopkins Medicine. (n.d.). *Diversity & inclusion 2020.* Retrieved from http://www.hopkinsmedicine.org/bin/s/x/diversity_and_inclusion.pdf
Johns Hopkins Medicine. (n.d.). *Diversity and inclusion at Johns Hopkins: Commitment, passion, engagement.* Retrieved from http://www.hopkinsmedicine.org/diversity/index.html
Johns Hopkins University. (2012). *Johns Hopkins Urban Health Institute.* Retrieved from http://urbanhealth.jhu.edu/
The Joint Commission. (2010). Patient communication assessment tool [Figure 5-1]. In *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals.* Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
The Joint Commission. (2011). *Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: A field guide*. Retrieved from http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf
Journal of Multicultural Counseling and Development. (2012). Retrieved from http://www.jmcdonline.org/
Journal of Religion and Health. (n.d.). Retrieved from http://www.springer.com/public+health/journal/10943
Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy. (2003). B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1

Principal Standard Resources
Kleinman, A. (1981). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry.* Berkeley, CA: University of California Press.
Kline, M. V. (1999). Planning health promotion and disease prevention programs in multicultural populations. In R. M. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 73–102). Thousand Oaks, CA: SAGE Publications, Inc.
Kutob, R. M., Senf, J. H., & Harris, J. M. (2009). Teaching culturally effective diabetes care: Results of a randomized controlled trial. *Family Medicine, 41*(3), 167–174. Retrieved from http://www.stfm.org/fmhub/fm2009/March/Randa167.pdf
Lighthouse International. (n.d.). Retrieved from http://www.lighthouse.org
Massachusetts Department of Public Health, Office of Health Equity. (2009). *Making CLAS happen: Six areas for action.* Retrieved from http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/health-equity/clas/making-clas-happen.html
Massachusetts General Hospital, The Committee on Racial and Ethnic Disparities. (n.d.). *Subcommittees.* Retrieved from http://www.mghdisparities.org/sub_quality.html
Meade, C., Menard, J., Martinez, D., & Calvo, A. (2007). Impacting health disparities through community outreach: Utilizing the CLEAN look (culture, literacy, education, assessment, and networking). *Cancer Control, 14*(1), 70–77. Retrieved from http://www.moffitt.org/CCJRoot/v14n1/pdf/70.pdf
MedlinePlus. (2012). *Rural health concerns.* Retrieved from http://www.nlm.nih.gov/medlineplus/ruralhealthconcerns.html
National Coalition for LGBT Health. (n.d.). Retrieved from http://lgbthealth.webolutionary.com/
National Committee for Quality Assurance. (2009). *Implementing multicultural health care standards: Ideas and examples.* Retrieved from http://www.ncqa.org/Portals/0/Publications/Implementing%20MHC%20Standards%20Ideas%20and%20Examples%2004%2029%2010.pdf
National Committee for Quality Assurance. (2011). *Awards: Recognizing innovations in multicultural health care.* Retrieved from http://www.ncqa.org/tabid/453/Default.aspx
National Council on Interpreting in Health Care. (2011). Retrieved from http://www.ncihc.org
National Health Law Program. (2010). Retrieved from http://www.healthlaw.org/
National Health Plan Collaborative. (2008). *The national health plan collaborative toolkit.* Retrieved from Robert Wood Johnson Foundation website: http://www.rwjf.org/qualityequality/product.jsp?id=33960

Principal Standard Resources
National Partnership for Action to End Health Disparities. (2011). *National stakeholder strategy for achieving health equity.* Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286
National Patient Safety Foundation. (n.d.). *Ask me 3.* Retrieved from http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3
National Quality Forum. (2005). *Implementing a national voluntary consensus standard for informed consent: A user's guide for healthcare professionals.* Retrieved from http://www.qualityforum.org/Publications/2005/09/Implementing_a_National_Voluntary_Consensus_Standard_for_Informed_Consent__A_User%e2%80%99s_Guide_for_Healthcare_Professionals.aspx
National Quality Forum. (2005). *Improving patient safety through informed consent for patients with limited health literacy.* Retrieved from http://www.qualityforum.org/Publications/2005/09/Improving_Patient_Safety_Through_Informed_Consent_for_Patients_with_Limited_Health_Literacy.aspx
National Quality Forum. (2009). *A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report.* Retrieved from http://www.cpehn.org/pdfs/Cultural%20Competency%20-%20NQF.pdf
National Rural Health Association. (2012). Retrieved from http://www.ruralhealthweb.org/
National Rural Health Association. (2012). *Rural Multiracial and Multicultural Health Conference.* http://www.ruralhealthweb.org/go/events/rural-multiracial-and-multicultural-health-conference
New York State Office of Mental Health Office of Quality Management. (2011). *Quality improvement plan template.* Retrieved from http://omh.ny.gov/omhweb/cqi/plan_template.html
Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care, 8*(5), 491–497. doi:10.1093/intqh/8.5.491
Patak, L., Wilson-Stronks, A., Costello, J., Kleinpell, R., Henneman, E., Person, C., & Happ, M. B. (2009). Improving patient-provider communication: A call to action. *Journal of Nursing Administration, 39*(9), 372–376. doi:10.1097/NNA.0b013e3181b414ca
Pfizer. (2011). *Prevalence calculator.* Retrieved from http://www.pfizerhealthliteracy.com/physicians-providers/PrevalenceCalculator.aspx
Putsch, R., SenGupta, I., Sampson, A., & Tervalon, M. (2003). *Reflections on the CLAS Standards: Best practices, innovations and horizons.* Retrieved from The Cross Cultural Health Care Program website: http://www.xculture.org/files/CLAS.Standards.Report.pdf.pdf

Principal Standard Resources
QSource, Underserved Quality Improvement Organization Support Center. (2005). *CLAS Standards implementation tips.* Retrieved from http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf
Refugee Health Technical Assistance Center. (2011). Retrieved from http://www.refugeehealthta.org/
Robert Wood Johnson Foundation. (2008). *Speaking together toolkit.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=29653
Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2824588
Salimbene, S. (2001). *CLAS A–Z: A practical guide for implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care.* Retrieved from Office of Minority Health website: http://minorityhealth.hhs.gov/assets/pdf/checked/CLAS_a2z.pdf
Savinar, R. (n.d.). *California take on "promotora" model of community outreach a success.* Retrieved from Proyecto Vision website: http://www.proyectovision.net/english/news/13/promotoras.html
Smith, W., Betancourt, J., Wynia, M., Bussey-Jones J., Stone, V., Phillips, C., … & Bowles, J. (2007). Recommendations for teaching about racial and ethnic disparities in health and health care. *Annals of Internal Medicine, 147*(9), 654–665.
Spector, R. E. (2008). *Cultural diversity in health & illness* (7th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
Spiritual Diversity and Social Work Resource Center. (n.d.). Retrieved from http://www.socwel.ku.edu/candagrant/hfc4.htm
State Government of Victoria, Australia, Department of Health, Rural and Regional Health and Aged Care Services. (2009). *Cultural responsiveness framework: Guidelines for Victorian health services*. Retrieved from http://www.health.vic.gov.au/__data/assets/pdf_file/0008/381068/cultural_responsiveness.pdf
Stonecypher, K. (2009). Creating a patient education tool. *Journal of Continuing Education in Nursing, 40*(10), 462–467. doi:10.3928/00220124-20090923-06
Tanenbaum Center for Interreligious Understanding. (2009). *The medical manual for religio-cultural competence: Caring for religiously diverse populations.* New York, NY: Tanenbaum Center for Interreligious Understanding.
Transcultural Nursing Society. (2012). Retrieved from http://www.tcns.org/
University of California, San Francisco. (2008). *LGBT resource center.* Retrieved from http://lgbt.ucsf.edu/services_health.html

Principal Standard Resources
University of Illinois at Urbana-Champaign, McKinley Health Center. (2009). *Multicultural health clearinghouse.* Retrieved from http://www.mckinley.illinois.edu/multiculturalhealth/index.htm
University of Rochester Medical Center. (2012). *National Center for Deaf Health Research.* Retrieved from http://www.urmc.rochester.edu/ncdhr/
U.S. Department of Commerce, Census Bureau. (2004). *2004 U.S. Census test: Language identification flashcard.* Retrieved from http://www.lep.gov/ISpeakCards2004.pdf
U.S. Department of Health and Human Services. (2011). *HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care.* Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Developing quality of care measures for people with disabilities: Summary of expert meeting* (AHRQ Publication No. 10-0103). Retrieved from http://www.ahrq.gov/populations/devqmdis/devqmdis.pdf
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Health literacy universal precautions toolkit* (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *2010 national healthcare disparities report* (AHRQ Publication No. 11-0005). Retrieved from http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS cultural competence item set.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/cultural-competence.aspx
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *Ensuring that patient centered medical homes effectively serve patients with complex needs* (AHRQ Publication No. 11-0109). Retrieved from http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_tools__resources_patient-centered_v2
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012). *Coordinating care for adults with complex care needs in the patient-centered medical home: Challenges and solutions* (AHRQ Publication No. 12-0010). Retrieved from http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_tools__resources_coordinated_care_v2
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012). *AHRQ Healthcare Innovations Exchange: Innovations and tools to improve quality and reduce disparities.* Retrieved from http://www.innovations.ahrq.gov/

Principal Standard Resources
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (n.d.) *Intellectual disability fact sheet.* Retrieved from http://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/IntellectualDisability.pdf
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2011). *Lesbian, gay, bisexual and transgender health.* Retrieved from http://www.cdc.gov/lgbthealth
U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons.* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html
U.S. Department of Health and Human Services, Office of Minority Health. (2011). *National Partnership for Action to End Health Disparities.* Retrieved from http://minorityhealth.hhs.gov/npa
U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *Think cultural health: Advancing health equity at every point of contact.* Retrieved from https://www.thinkculturalhealth.hhs.gov
U.S. Department of Health and Human Services, Specialized Information Services. (2012). *Outreach activities and resources: Multi-cultural resources for health information.* Retrieved from http://sis.nlm.nih.gov/outreach/multicultural.html
U.S. Department of Health and Human Services, Administration on Aging. (2010). *A toolkit for serving diverse communities.* Retrieved from http://www.aoa.gov/AOARoot/AoA_Programs/Tools_Resources/DOCS/AoA_DiversityToolkit_Full.pdf
Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf
Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf
Wynia, M., & Matiasek, J. (2006). *Promising practices for patient-centered communication with vulnerable populations: Examples from eight hospitals* (Commonwealth Fund Publication No. 947). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Aug/Promising%20Practices%20for%20Patient%20Centered%20Communication%20with%20Vulnerable%20Populations%20%20Examples%20from%20Ei/Wynia_promisingpracticespatientcentered_947%20pdf.pdf
Youdelman, M., & Perkins, J. (2005). Promising practices for small health care providers. In *Providing language services in small health care provider settings: Examples from the field* (pp. 3–11) (Commonwealth Fund Publication No. 810). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf

Theme 1 Resources
Accreditation Council for Graduate Medical Education. (2011). *Common program requirements*. Retrieved from http://www.acgme.org/acwebsite/home/common_program_requirements_07012011.pdf
American Academy of Family Physicians. (2001). *Quality care for diverse populations videos* [Video series]. Available from http://www.aafp.org/online/en/home/clinical/publichealth/culturalprof/quality-care-diverse-populations.html
American Academy on Communication in Healthcare. (n.d.). *Skills based courses* [Course summaries]. Retrieved from http://www.aachonline.org/?page=SkillsBasedCourses
American Medical Association, The Ethical Force Program. (2006). Content area 4. Develop workforce. In *Improving communication—improving care: How health care organizations can ensure effective, patient-centered communication with people from diverse populations* (pp. 47–54). Retrieved from http://www.ama-assn.org/resources/doc/ethics/pcc-consensus-report.pdf
American Medical Association. (2012). *C-CAT: Patient centered communication.* Retrieved from http://www.ama-assn.org/go/ccat
American Medical Association. (2012). *The Ethical Force Program.* Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program.page
Archer, D. (Producer), & Silver, J. (Director). (1997). *A world of differences: Understanding cross-cultural communication* [DVD]. United States: University of California Extension Center for Media and Independent Learning.
Association of American Medical Colleges (n.d.). *Tool for assessing cultural competence training (TACCT).* Retrieved from https://www.aamc.org/initiatives/tacct/
Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., … Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care, 43*(4), 356–373.
Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine, 78*(6), 560–569.
Betancourt, J., Green, A., & King, R. (2008). *Improving quality and achieving equity: A guide for hospital leaders.* Retrieved from Massachusetts General Hospital, The Disparities Solutions Center website: http://www2.massgeneral.org/disparitiessolutions/z_files/disparities%20leadership%20guide_final.pdf

Theme 1 Resources
Carter-Pokras, O., Acosta, D. A., Lie, D., Bereknyei, S., DeLisser, H., Haidet, P., … Glick, S. (2009). *Practice what you teach: Curricular products from the National Consortium for Multicultural Education for Health Professionals*. Retrieved from http://culturalmeded.stanford.edu/pdf%20docs/Focus%20MDNG%20NCME%20curricular%20products.pdf
Cross Cultural Health Care Program. (n.d.). *Course information: Bridging the gap* [Online training course summary]. Retrieved from http://www.xculture.org/BTGclassdesc.php
Echeverri, M., Brookover, C., & Kennedy, K. (2010). Nine constructs of cultural competence for curriculum development. *American Journal of Pharmaceutical Education, 74*(10), Article 181. Retrieved from http://www.ajpe.org/doi/pdf/10.5688/aj7410181
Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, National Center for Cultural Competence. (2000). *A planner's guide: Infusing principles, content and themes related to cultural and linguistic competence into meetings and conferences.* Retrieved from http://gucchd.georgetown.edu/products/PlannersGuide.pdf
Gilbert, M. J. (Ed.). (2003). *A manager's guide to cultural competence education for health care professionals.* Retrieved from The California Endowment website: http://www.calendow.org/uploadedFiles/managers_guide_cultural_competence(1).pdf
Gilbert, M. J. (Ed.). (2003). *Principles and recommended standards for cultural competence education of health care professionals.* Retrieved from The California Endowment website: http://www.calendow.org/uploadedFiles/principles_standards_cultural_competence.pdf
Gilbert, M. J. (Ed.). (2003). *Resources in cultural competence education for health care professionals*. Retrieved from The California Endowment website: http://www.calendow.org/uploadedFiles/resources_in_cultural_competence.pdf
Grainger-Monsen, M., & Haslett, J. (2004). *Worlds apart: A four-part series on cross-cultural healthcare* [Film series]. Fanlight Productions. Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/Multimedia/Videos/2004/Feb/Worlds-Apart---em--A-Film-Series-on-Cross-Cultural-Health-Care.aspx
Graves, D. L., Like, R. C., Kelly, N., & Hohensee, A. (2007). Legislation as intervention: A survey of cultural competence policy in health care. *Journal of Health Care Law and Policy, 10*(2), 339–361. Retrieved from http://thecqc.org/uploads/Graves_et_al.pdf
Hark, A. L., & DeLisser, H. M. (Eds.). (2009). *Achieving cultural competency: A case-based approach to training health professionals.* Oxford, UK: Wiley-Blackwell.
Institute for Diversity in Health Management. (2004). *Strategies for leadership: Does your hospital reflect the community it serves? Diversity and cultural proficiency assessment tool for leaders.* Retrieved from http://www.aha.org/content/00-10/diversitytool.pdf

Theme 1 Resources
Institute for Diversity in Health Management. (2008). *Institute Resource Center.* Retrieved from http://www.diversityconnection.org/diversityconnection/membership/Institute-Resource-Center.jsp?fll=S12
Institute for Healthcare Communication. (2012). *Training*. Retrieved from http://healthcarecomm.org/training
Khanna, S. K., Cheyney, M., & Engle, M. (2009). Cultural competency in health care: Evaluating the outcomes of a cultural competency training among health care professionals. *Journal of National Medical Association, 101,* 886–892.
Kripalani, S., & Jacobson, K. L. (2007). *Strategies to improve communication between pharmacy staff and patients: Training program for pharmacy staff* [Curriculum guide] (AHRQ Publication No. 07(08)-0051-1-EF). Retrieved from http://www.ahrq.gov/qual/pharmlit/pharmtrain.htm
Liaison Committee on Medical Education. (2011). *Functions and structure of a medical school: standards for accreditation of medical education programs leading to the M.D. degree. IS-16, ED-21, ED-22*. Retrieved from http://www.lcme.org/functions2011may.pdf
Lie, D., Boker, J., & Cleveland, E. (2006). Using the tool for assessing cultural competence training (TACCT) to measure faculty and medical student perceptions of cultural competence instruction in the first three years of the curriculum. *Academic Medicine, 81,* 557–564. doi:10.1097/01.ACM.0000225219.53325.52
Lie, D. A., Boker, J., Crandall, S., DeGannes, C. N., Elliott, D., Henderson, P., … Seng, L. (2008). Revising the tool for assessing cultural competence training (TACCT) for curriculum evaluation: Findings derived from seven US schools and expert consensus. *Medical Education Online, 13*(11), 1–11. doi:10.3885/meo.2008.Res00272
Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock, C. H., 3rd. (2010). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine, 26*(3), 317–325. doi:10.1007/s11606-010-1529-0
Like, R. C. (2001). *Clinical cultural competency questionnaire*. Retrieved from Robert Wood Johnson Medical School website: http://rwjms.umdnj.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.html
Like, R. C. (2011). Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions, 31*(3), 196–206.
Like, R. C., Steiner, R. P., & Rubel, A. J. (1996). Recommended core curriculum guidelines on culturally sensitive and competent health care. *Family Medicine, 28,* 291–297. Retrieved from http://www.stfm.org/corep.html

Theme 1 Resources
Liteman, M., Campbell, S., & Liteman, J. (2006). *Retreats that work: Everything you need to know about planning and leading great offsites.* San Francisco, CA: Pfeiffer.
Management Sciences for Health. (n.d.). *The provider's guide to quality & culture.* Retrieved from http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
McDougle, L., Ukockis, G., & Adamshick, L. (2010). Evaluation of a new cultural competency training program: CARE Columbus. *Journal of the National Medical Association, 102*(9), 756–760.
National Council on Interpreting in Health Care. (2004). *A national code of ethics for interpreters in health care.* Retrieved from http://www.oregon.gov/OHA/oei/intrprtr/docs/NCIHC_NCE.pdf
National Hispanic Health Foundation & the Josiah Macy, Jr. Foundation. (2009). *Increasing diversity in the health professions: Recommendations to improve Title VII of the Public Health Service Act.* Retrieved from http://josiahmacyfoundation.org/docs/grantee_pubs/NHHF-Macy_PHSA_Recs.pdf
National Quality Forum. (2009). *Safe practices for better healthcare–2009 update: A consensus report.* Retrieved from http://www.qualityforum.org/Publications/2009/03/Safe_Practices_for_Better_Healthcare%e2%80%932009_Update.aspx
Paez, K. A., Allen, J. K., Carson, K. A., & Cooper, L. A. (2008). Provider and clinic cultural competence in a primary care setting. *Social Science and Medicine, 66*(5), 1204–1216. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2426909/?tool=pubmed
Patient-Centered Primary Care Collaborative. (n.d.). Retrieved from http://www.pcpcc.net
Powell, L., & Taylor, C. (2004). *Hospital governing board assessment: A self-help guide.* Boise, ID: Mountain States Group.
Price, E. G., Beach, M. C., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., ... Cooper, L. A. (2005). A systematic review of the methodologic rigor of studies evaluating cultural competence training of health professionals. *Academic Medicine, 80,* 578–586. Retrieved from http://journals.lww.com/academicmedicine/Fulltext/2005/06000/A_Systematic_Review_of_the_Methodological_Rigor_of.13.aspx
Quality interactions: A patient-based approach to cross-cultural care. (2011). Retrieved from http://www.qualityinteractions.org
Ring, J., Nyquist, J., Mitchell, S., Flores, H., & Samaniego, L. (2008). *Curriculum for culturally responsive health care: The step-by-step guide for cultural competence training.* Oxford, UK: Radcliffe Publishing.
Schyve, P. M., & The Governance Institute. (2009). *Leadership in healthcare organizations: A guide to Joint Commission leadership standards.* Retrieved from http://www.jointcommission.org/assets/1/18/WP_Leadership_Standards.pdf

Theme 1 Resources
Sequist, T. D., Fitzmaurice, G. M., Marshall, R., Shaykevich, S., Marston, A., Safran, D. G., & Ayanian, J. Z. (2010). Cultural competency training and performance reports to improve diabetes care for black patients: A cluster randomized, controlled trial. *Annals of Internal Medicine, 152*(1), 40–46.
Smedley, B. D., Stith-Butler, A., & Bristow, L. R. (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce.* Retrieved from http://www.nap.edu/openbook.php?record_id=10885&page=1
The Sullivan Commission on Diversity in the Healthcare Workforce. (2004). *Missing persons: Minorities in the health professions*. Retrieved from http://www.aacn.nche.edu/media-relations/SullivanReport.pdf
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (n.d.). *Training and continuing education online: Health literacy for public health professionals (web-based)* [Online training course summary]. Retrieved from http://www2a.cdc.gov/tceonline/registration/detailpage.asp?res_id=2074
U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Unified health communication 101.* Retrieved from http://www.hrsa.gov/publichealth/healthliteracy/index.html
U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations*. Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf
U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *A physician's practical guide to culturally competent care.* Retrieved from https://cccm.thinkculturalhealth.hhs.gov/
U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *Cultural competency curriculum for disaster preparedness and crisis response.* Retrieved from https://cccdpcr.thinkculturalhealth.hhs.gov/
U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *Culturally competent nursing care: A cornerstone of caring.* Retrieved from https://ccnm.thinkculturalhealth.hhs.gov/
Virtual Lecture Hall. (2012). *Communicating through health care interpreters* [Online training course summary]. Retrieved from http://www.vlh.com/shared/courses/course_info.cfm?courseno=155
Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428

Theme 2 Resources
Adelson, B. L., & Bromberg & Associates, LLC. (2010). *Title VI for healthcare and healthcare-related organizations* [Online training module]. Hamtramck, MI: Bromberg Translation Services.
American Medical Association Foundation. (2007). *Health literacy and patient safety: Help your patients understand* [Educational kit]. Chicago, IL: American Medical Association Foundation.
American Medical Association. (n.d.). *C-CAT: Patient centered communication.* Retrieved from http://www.ama-assn.org/go/ccat
American Medical Association. (2007). *Office guide to communicating with limited English proficient patients*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf
American Speech-Language-Hearing Association. (2012). *National Joint Committee for the Communication Needs of Persons with Severe Disabilities (NJC)*. Retrieved from http://www.asha.org/njc
Anderson, C. C., & National Council on Interpreting in Health Care (2002). *Linguistically appropriate access and services: An evaluation and review for healthcare organizations.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Linguistically%20Appropriate%20Access%20and%20Services.pdf
Andrulis, D. P., & Brach, C. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American Journal of Health Behavior, 31,* S122–S133. Retrieved from http://www.cpehn.org/pdfs/Integrating%20Literace%20Paper%20-%20Andrulis.pdf
Andrus, M. R., & Roth, M. T. (2002). Health literacy: A review. *Pharmacotherapy, 22*(3), 282–302. Retrieved from www.cce.uri.edu/pharmacy/rotationdescriptions/Andrus_Wk2.pdf
Berger, C. (2005). *Universal symbols in health care workbook*. Retrieved from Hablamos Juntos website: http://www.hablamosjuntos.org/signage/PDF/Best%20Practices-FINALDec05.pdf
Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine, 155*(2), 97–107.
Brach C., Keller, D, Hernandez, L., Baur, C., Parker, R., Schyve, P., Lemerise, & Schillinger, D. (2012). Ten Attributes of Health Literate Health Care Organizations. Washington DC. Retrieved from: http://www.iom.edu/Activities/PublicHealth/HealthLiteracy.aspx
Brach, C., Fraser, I., & Perez, K. (2005). Crossing the language chasm. *Health Affairs, 24*(2), 424–434. doi:10.1377/hlthaff.24.2.424
California Academy of Family Physicians. (2005). *Addressing language access issues in your practice: A toolkit for physicians and their staff members.* Retrieved from http://www.calendow.org/uploadedFiles/language_access_issues.pdf

Theme 2 Resources
California Healthcare Interpreting Association. (n.d.). Retrieved from http://chiaonline.org/
Centers for Medicare & Medicaid Services. (2011). *The toolkit for making written material clear and effective: Overview*. Retrieved from https://www.cms.gov/WrittenMaterialsToolkit/
Certification Commission for Healthcare Interpreters. (n.d.). Retrieved from http://www.healthcareinterpretercertification.org/
Chen, A. (2006). Doctoring across the language divide. *Health Affairs, 25*(3), 808–813. doi:10.1377/hlthaff.25.3.808
Chen, A. H., Youdelman, M. K., & Brooks, J. (2007). The legal framework for language access in healthcare settings: Title VI and beyond. *Journal of General Internal Medicine, 22*(Supplement 2), 362–367. doi:10.1007/s11606-007-0366-2
Commonwealth of Massachusetts Executive Office of Health and Human Services, Massachusetts Department of Public Health. (2004). *Best practice recommendations for hospital-based interpreter services.* Retrieved from http://www.hablamosjuntos.org/pdf_files/Best_Practice_Recommendations_Feb2004.pdf
Cross-Cultural Communication Systems, Inc. (2010). Retrieved from http://www.embracingculture.com
The Cross Cultural Health Care Program. (n.d.). *Communicating effectively through an interpreter* [DVD]. Seattle, WA: The Cross Cultural Health Care Program.
Divi, C., Koss, R. G., Schmaltz, S. P., & Loeb, J. M. (2007). Language proficiency and adverse events in US hospitals: A pilot study. *International Journal of Quality in Health Care, 19*(2), 60–67. doi:10.1093/intqhc/mzl069
Downing, B., & Bogoslaw, L. (2003). *Translation as a strategy for effective communication with patients and clients: A how-to guide*. Retrieved from Hablamos Juntos website: http://www.hablamosjuntos.org/pdf_files/BruceDowningHow-To_Guide_FINAL.pdf
Ferguson, L. A., & Pawlak, R. (2011). Health literacy: The road to improved health outcomes. *Journal for Nurse Practitioners, 7*(2), 123–129. doi:10.1016/j.nurpra.2010.11.020
Gilbert, M. J., Partida, Y., Goode, T., & Dunne, C. (2005). Process of inquiry: Communicating in a multicultural environment. In *Curricula enhancement module series*. Retrieved from the National Center for Cultural Competence website: http://www.nccccurricula.info/communication/index.html
Grubbs, V., Chen, A. H., Bindman, A. B., Vittinghoff, E., & Fernandez, A. (2006). Effect of awareness of language law on language access in the health care setting. *Journal of General Internal Medicine, 21*(7), 683–688. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924696/?tool=pubmed

Theme 2 Resources
Hablamos Juntos: Language policy and practice in health care. (n.d.). Retrieved from http://www.hablamosjuntos.org
Hablamos Juntos. (2008). *Language testing options 2008.* Retrieved from http://www.imiaweb.org/uploads/pages/218.pdf
Harvard School of Public Health. (2010). *Health literacy studies: Assessing and developing health materials.* Retrieved from http://www.hsph.harvard.edu/healthliteracy/practice/innovative-actions/index.html
Health Care Interpreter Network, Kaiser Permanente, & Casa Madre Films. (2009). *Qualified interpreting for quality health care* [DVD]. Retrieved from http://vimeo.com/7225401
Health Literacy Innovations. (2008). *The health literacy & plain language resource guide.* Retrieved from http://www.healthliteracyinnovations.com/information/RGdownload
Hunt, D., & Walker, P. F. (2010). *Language access and the law: Caring for the LEP patient* [E-learning program]. Minneapolis, MN: Critical Measures.
International Medical Interpreters Association. (1995). *Medical interpreting standards of practice.* Retrieved from http://www.hablamosjuntos.org/resources/pdf/IMIA_Standards_Of_Practice.pdf
International Medical Interpreters Association. (2012). Retrieved from http://www.imiaweb.org/default.asp
The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
Kelly, N. (2007). *Telephone interpreting in health care settings: Some commonly asked questions*. Retrieved from The ATA Chronicle website: http://www.atanet.org/chronicle/feature_article_june2007.php
Kelly, N. (2008). *A medical interpreter's guide to telephone interpreting*. Retrieved from International Medical Interpreters Association website: http://www.imiaweb.org/uploads/pages/380.pdf
Kuo, D. Z., O'Connor, K. G., Flores, G., & Minkovitz, C. S. (2007). Pediatricians' use of language services for families with limited English proficiency. *Pediatrics 119*(4), e920–e27. doi:10.1542/peds.2006-1508.
Limited English proficiency: A federal interagency website. (n.d.). Retrieved from http://www.lep.gov
LinguaLinks Library. (1999). *Correspondence of proficiency scales*. Retrieved from http://www.sil.org/lingualinks/LANGUAGELEARNING/MangngYrLnggLrnngPrgrm/CorrespondenceOfProficiencySca.htm

Theme 2 Resources
Meyers, K., Tang, G., & Fernandez, A. (2009). Responding to the language challenge: Kaiser Permanente's approach. *The Permanente Journal, 13*(3), 77–83. Retrieved from http://www.thepermanentejournal.org/files/Summer2009/language_challenge.pdf
National Association of the Deaf. (2012). Retrieved from http://www.nad.org/
National Board of Certification for Medical Interpreters. (2012). Retrieved from http://www.certifiedmedicalinterpreters.org/
National Council on Interpreting in Health Care. (2011). Retrieved from http://www.ncihc.org
National Council on Interpreting in Health Care. (2001). *Guide to initial assessment of interpreter qualifications.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20Guide%20to%20Initial%20Assessment%20of%20Interpreter%20Qualifications.pdf
National Council on Interpreting in Health Care. (2003). *Guide to interpreter positioning in health care settings.* Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Guide%20to%20Interpreter%20Positioning%20in%20Health%20Care%20Settings.pdf
National Council on Interpreting in Health Care. (2005). *National standards of practice for interpreters in health care.* Retrieved from http://mchb.hrsa.gov/training/documents/pdf_library/National_Standards_of_Practice_for_Interpreters_in_Health_Care%20(12-05).pdf
National Council on Interpreting in Health Care. (2010). *Sight translation and written translation: Guidelines for healthcare interpreters.* Retrieved from http://data.memberclicks.com/site/ncihc/Translation%20Guidelines%20for%20Interpreters%20REVISED%2031710.pdf
National Health Law Program. (2010). *What's in a word? A guide to understanding interpreting and translation in health care.* Retrieved from http://www.healthlaw.org/images/stories/Whats_in_a_Word_Guide.pdf
National Health Law Program. (2010). *Language access.* Retrieved from http://www.healthlaw.org/index.php?option=com_content&id=239&Itemid=196
Osborne, H. (2001, November). *In other words…Can they understand? Testing patient education materials with intended readers.* Retrieved from http://www.healthliteracy.com/article.asp?PageID=3811 (Reprinted from the *Boston Globe On Call* magazine)
Paras, M. (2005). *Straight talk: Model hospital policies and procedures on language access.* Retrieved from http://www.calendow.org/uploadedFiles/straight_talk_model_hospital_policies.pdf
Pierce, L. (2010). How to choose and develop written educational materials. *Rehabilitation Nursing, 35*(3), 99–105. Retrieved from http://www.rehabnurse.org/pdf/rnj320.pdf

Theme 2 Resources
Plain Language Association International. (2011). Retrieved from http://www.plainlanguagenetwork.org/
Quan, K., & Lynch, J. (2010). *The high costs of language barriers in medical malpractice.* Retrieved from National Health Law Program website: http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf
Registry of Interpreters for the Deaf. (2012). *Standard practice papers.* Retrieved from http://www.rid.org/interpreting/Standard%20Practice%20Papers/index.cfm
Registry of Interpreters for the Deaf. (2012). Retrieved from http://www.rid.org
Roat, C. E. (2005). *Assessing language access issues in your practice: A toolkit for physicians and their staff members.* Retrieved from The California Endowment website: http://www.calendow.org//uploadedFiles//language_access_issues.pdf
Robert Wood Johnson Foundation. (2008). *Kaiser Permanente's health care interpreter certificate program.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=34036
Robert Wood Johnson Foundation. (2008). *Kaiser Permanente's qualified bilingual staff model.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=34030
Robert Wood Johnson Foundation. (2008). *Speaking together toolkit.* Retrieved from http://www.rwjf.org/pr/product.jsp?id=29653
Robert Wood Johnson Foundation. (n.d.). *Shared decision-making when an interpreter is needed: A case study with Latino men at risk for prostate cancer* (Grant details). Retrieved from http://www.rwjf.org/grants/grant.jsp?id=63830
Tang, G., Lanza, O., & Rodriguez, F. M. (2011). Case study: The language of diversity. *Diversity Executive,* 44–46. Retrieved from http://diversity-executive.com/articles/view/1160
Tang, G., Lanza, O., Rodriguez, F. M., & Chang, A. (2011). The Kaiser clinician cultural and linguistic assessment initiative: Research and development in patient-provider language concordance. *American Journal of Public Health, 101*(2), 205–208.
Trott, J., West, C., Shah, P., & Regenstein, M. (2008). *Building a high-quality language services program toolkit.* Retrieved from http://www.lawhelp.org/documents/391611Building%20a%20High-Quality%20Language%20Services%20Program%20Toolkit.pdf
Txabarriaga, R. (2009). *IMIA guide on medical translation.* Retrieved from International Medical Interpreters Association website: http://www.imiaweb.org/uploads/pages/438.pdf
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS item set for addressing health literacy.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/health-literacy.aspx

Theme 2 Resources
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). *Health literacy universal precautions toolkit* (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/
U.S. Department of Health and Human Services, Office for Civil Rights. (2003). *Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons.* Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html
U.S. Department of Justice, Civil Rights Division. (n.d.). *Federal agency LEP guidance & language access plans*. Retrieved from http://www.lep.gov/guidance/guidance_index.html
U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *Health literacy online: A guide to writing and designing easy-to-use health web sites*. Retrieved from http://www.health.gov/healthliteracyonline
U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy.* Retrieved from http://www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf
U.S. Department of Health and Human Services, Office of Minority Health. (2005). *A patient-centered guide to implementing language access services in healthcare organizations*. Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf
Virtual Lecture Hall. (2012). *Communicating through health care interpreters* [Online training course summary]. Retrieved from http://www.vlh.com/shared/courses/course_info.cfm?courseno=155
Wynia, M. K., Johnson, M., McCoy, T. P., Passmore Griffin, L., & Osborn, C. Y. (2010). Validation of an organizational communication climate assessment toolkit. *American Journal of Medical Quality, 25*(6), 436–443. doi:10.1177/1062860610368428
Wynia, M., & Matiasek, J. (2006). *Promising practices for patient-centered communication with vulnerable populations: Examples from eight hospitals* (Commonwealth Fund Publication No. 947). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Aug/Promising%20Practices%20for%20Patient%20Centered%20Communication%20with%20Vulnerable%20Populations%20%20Examples%20from%20Ei/Wynia_promisingpracticespatientcentered_947%20pdf.pdf

Theme 3 Resources
American Medical Association. (n.d.). *C-CAT: Patient centered communication.* Retrieved from http://www.ama-assn.org/go/ccat
Asset-Based Community Development Institute. (2009). Retrieved from http://www.abcdinstitute.org/
Association of the Bar of the City of New York. (n.d.). *Diversity committees that make a difference.* Retrieved from http://www.akcsystems.com/test3/images/stories/pdfs/Diversity%20Committee%20Notes%20Article10_2004.pdf
Aubel, J. (1999). *Participatory program evaluation manual: Involving program stakeholders in the evaluation process.* Retrieved from http://www.idrc.ca/uploads/user-S/10504133390Participatory_Program_Evaluation_Manual.pdf
Baker, Q. E., Davis, D. A., Gallerani, R., Sanchez, V., Viadro, C., & The Center for the Advancement of Community Based Public Health. (2000). *An evaluation framework for community health programs.* Retrieved from http://www.doh.state.fl.us/COMPASS/documents/Community_Health_Programs_Eval.pdf
Baker, S., Conrad, D., Béchamps, M., & Barry M. (2002). *Healthy people toolkit 2010: A field guide to health planning*. Retrieved from Public Health Foundation website: http://www.phf.org/resourcestools/Documents/HP2010Toolkit2002.pdf
Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., … Powe, N. R. (2004). *Strategies for improving minority healthcare quality* (AHRQ Publication No. 04-E008-02). Retrieved from Agency for Healthcare Research and Quality website: http://archive.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf
Betancourt, J. R., Weissman, J. S., Kim, M. K., Park, E., & Maina, A. W. (2007). *Resident physicians' preparedness to provide cross-cultural care: Implications for clinical care and medical education policy*. Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/1026_Betancourt_resident_MDs_preparedness_provide_cross-cultural_care.pdf
Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7,* 15. doi:10.1186/1472-6963-7-15
Campinha-Bacote, J. (2002). *Inventory for assessing the process of cultural competence among healthcare professionals-revised (IAPCC-R).* Retrieved from http://www.transculturalcare.net/iapcc-r.htm
CASAS. (2011). Retrieved from https://www.casas.org
Johns Hopkins University. (2010). *COA360*. Retrieved from http://www.COA360.org
Clinical and Translational Science Awards Consortium, Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. (2011). *Principles of community engagement* (2nd ed.) (National Institutes of Health Publication No. 11-7782). Retrieved from http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Theme 3 Resources
Cummings, L. C., Bennett, B. A., Boutwell, A. E., & Martinez, E. L. (2008). *Assuring healthcare quality: A healthcare equity blueprint.* Retrieved from http://www2.massgeneral.org/disparitiessolutions/resources.html
Dator, J. (1991). *Culturally-appropriate dispute resolution techniques and the formal judicial system in Hawaii. A report to the state justice institute.* Retrieved from http://www.futures.hawaii.edu/publications/courts/CultAppropAD1991.pdf
Drucker, P. F. (1998). *The Drucker Foundation self-assessment tool: Participant workbook.* Hoboken, NJ: Jossey-Bass, Inc.
DuPraw, M., & Axner, M. (2011). *Working on common cross-cultural communication challenges.* Retrieved from http://www.pbs.org/ampu/crosscult.html
Fiscella, K. (2011). Eliminating disparities in health care through quality improvement. In R. A. Williams (Ed.), *Healthcare disparities at the crossroads with healthcare reform* (pp. 231–267). New York, NY: Springer.
Hasnain-Wynia, R., & Baker, D. W. (2006). Obtaining data on patient race, ethnicity, and primary language in health care organizations: Current challenges and proposed solutions. *Health Services Research, 41,* 1501–1518. doi:10.1111/j.1475-6773.2006.00552.x
Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., & Reiter, J. (2007). *Health Research and Educational Trust disparities toolkit.* Retrieved from http://www.hretdisparities.org/
Hasnain-Wynia, R., Van Dyke, K., Youdelman, M., Krautkramer, C., Ivey, S., Gilchick, R., Kaleba, E., & Wynia M. (2010). Barriers to collecting patient race, ethnicity and primary language data in physician practices: An exploratory study. *Journal of the National Medical Association, 102*(9), 769–775.
Institute for Patient- and Family-Centered Care. (2011). *Tools to foster the collaboration with patient and family advisors.* Retrieved from http://www.ipfcc.org/tools/downloads-tools.html
Johnson, M. J., & Kanitsaki, O. (2006). Culture, language, and patient safety: Making the link. *International Journal of Quality in Health Care, 18,* 383–388. Retrieved from http://intqhc.oxfordjournals.org/content/18/5/383.full.pdf
The Joint Commission. (2007). *"What did the doctor say?": Improving health literacy to protect patient safety.* Retrieved from http://www.jointcommission.org/assets/1/18/improving_health_literacy.pdf
Lahey Clinic Foundation. (2012). Retrieved from http://www.lahey.org/
LeBaron, M. (1998). *Mediation and multicultural reality.* Retrieved from http://www.gmu.edu/programs/icar/pcs/lebaron.htm

Theme 3 Resources
Leonhardt, K., Bonin, D., & Pagel, P. (2008). *Guide for developing a community-based patient safety advisory council* (AHRQ Publication No. 08-0048). Retrieved from http://www.ahrq.gov/qual/advisorycouncil/advisorycouncil.pdf
Management Sciences for Health. (n.d.). *The provider's guide to quality & culture.* Retrieved from http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
Mind Tools. (n.d.). *Conflict resolution: Resolving conflict rationally and effectively.* Retrieved from http://www.mindtools.com/pages/article/newLDR_81.htm
National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center. (2004). *Bridging the cultural divide in health care setting: The essential role of cultural broker programs.* Retrieved from http://gucchd.georgetown.edu/products/CulturalBrokerGuide_English.pdf
National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center. (n.d.). *Cultural competence health practitioner assessment (CCHPA).* Retrieved from http://nccc.georgetown.edu/features/CCHPA.html
National Committee for Quality Assurance. (2011). *Recognizing innovations in multicultural health care.* Retrieved from http://www.ncqa.org/tabid/453/Default.aspx
National Consensus Panel on Emergency Preparedness and Cultural Diversity. (2011). *Guidance for integrating culturally diverse communities into planning for and responding to emergencies: A toolkit* (HHS Office of Minority Health Publication No. OMH-NHMA-5-10). Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/emergencypre/omh_diversitytoolkit.pdf
National Quality Forum. (2008). *National voluntary consensus standards for ambulatory care: Measuring healthcare disparities.* Retrieved from http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx
National Quality Forum. (n.d.). *Cultural competency 2010: Cultural competency measures and implementation strategies.* Retrieved from http://www.qualityforum.org/Projects/c-d/Cultural_Competency_2010/Cultural_Competency_2010.aspx
Ohmans, P., & Cushing, M. (2000). *Getting the word out: Effective health outreach to cultural communities.* Retrieved from The Medtronic Foundation website: http://www.medtronic.com/downloadablefiles/outreach_brochure.pdf
Rice, M. F. (2007). Promoting cultural competency in public administration and public service delivery: Utilizing self-assessment tools and performance measures. *Journal of Public Affairs Education, 13,* 41–57.

Theme 3 Resources
Roat, C. (2003). *How to choose and use a language agency: A guide for health and social service providers who wish to contract with language agencies*. Retrieved from The California Endowment website: http://www.calendow.org/uploadedFiles/how_to_choose_use_language_agency.pdf
Rogers, S., & Vilhena, B. (2005). Benchmarking patient complaints data across Ontario hospitals: University Health Network invites collaboration [Online case study]. *Healthcare Quarterly*. Retrieved from http://www.longwoods.com/product/download/code/17728
San Francisco Department of Public Health. (n.d.). Retrieved from http://www.sfdph.org/dph/default.asp
Sandrick, K. (2006). Defining and measuring community benefit. *Trustee, 59*(9), 6–10. Retrieved from http://www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/PubsNewsArticleGen/data/2006October/0610TRU_CoverStory&domain=TRUSTEEMAG
Schillinger, D. (2010). *An introduction to effectiveness, dissemination and implementation research: A resource manual for community-engaged research*. Retrieved from http://accelerate.ucsf.edu/files/CE/edi_introguide.pdf
Sharpe, P. A., Greaney, M. L., Lee, P. R., & Royce, S. W. (2000). Assets-oriented community assessment. *Public Health Reports, 115,* 205–211. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308712/pdf/pubhealthrep00022-0103.pdf
Snowden, L. R. (2003). *Toward culturally competent evaluation in health and mental health.* Retrieved from The California Endowment website: http://www.calendow.org/uploadedFiles/Publications/Evaluation/toward_culturally_competent_evaluation.pdf
Summit Health Institute for Research and Education. (2004). *Building coalitions among communities of color: A multicultural approach.* Retrieved from http://www.shireinc.org/wp-content/files/Building_Coalitions_among_Communities_of_Color.pdf
Thom, D. H., & Tirado, M. D. (2006). Development and validation of a patient-reported measure of physician cultural competency. *Medical Care Research and Review, 63*(5), 636–655. doi:10.1177/1077558706290946
Torres, G., & Margolin, F. (2003). *The collaboration primer: Proven strategies, considerations, and tools to get you started.* Retrieved from Health Research and Educational Trust website: http://www.hret.org/upload/resources/collaboration-primer.pdf
Townsend, J. R. (2011). Creating a culturally and politically appropriate dispute resolution model: Working in Indian country. *RCAC's Rural Review, 28*(3), 1–7. Retrieved from http://www.rcac.org/assets/white-papers/CreatingACulturally.pdf
University of Colorado Conflict Information Consortium. (n.d.). Retrieved from http://conflict.colorado.edu/
University of Washington, Community-Campus Partnerships for Health. (n.d.). *Community-based participatory research.* Retrieved from http://depts.washington.edu/ccph/commbas.html

Theme 3 Resources
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2008). Hospital language services: Quality improvement and performance measures. In *Advances in patient safety: New directions and alternative approaches, Volume 2. Culture and redesign.* (AHRQ Publication No. 08-0034-2). Retrieved from http://www.ncbi.nih.gov/books/NBK43719
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS cultural competence item set.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/cultural-competence.aspx
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS item set for addressing health literacy.* Retrieved from https://www.cahps.ahrq.gov/surveys-guidance/item-sets/health-literacy.aspx
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *CAHPS: Surveys and tools to advance patient-centered care.* Retrieved from http://www.cahps.ahrq.gov
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (n.d.). *National healthcare quality and disparities reports.* Retrieved from http://www.ahrq.gov/qual/measurix.htm#quality
U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *Surveys on patient safety culture.* Retrieved from http://www.ahrq.gov/qual/patientsafetyculture/
U.S. Department of Health and Human Services, Health Resources and Services Administration. (2001). *Cultural competence works: Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements.* Retrieved from ftp://ftp.hrsa.gov/financeMC/cultural-competence.pdf
U.S. Department of Health and Human Services, Office of Minority Health. (2011). *Final data collection standards for race, ethnicity, primary language, sex, and disability status required by Section 4302 of the Affordable Care Act.* Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208
U.S. Department of Health and Human Services, Office of Minority Health. (2011). *Improving data for the LGBT community.* Retrieved from http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=209&id=9004
U.S. Department of Commerce, Census Bureau. (n.d.). *American factfinder.* Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Vogt, K. (2006, September). Mystery shopping gaining popularity in health care sector: The rise of consumer-directed care is one reason why physicians, hospitals and health plans are sending people incognito to learn how things are working. *American Medical News.* Retrieved from http://www.ama-assn.org/amednews/2006/09/18/bise0918.htm

Theme 3 Resources
Wang, S. (2006, August 8). Health care taps "mystery shoppers": To improve service, hospitals and doctors hire spies to pose as patients and report back. *Wall Street Journal.* Retrieved from http://online.wsj.com/article/SB115499684792929340.html
Weech-Maldonado, R. (2007, June). *Moving towards culturally competent health systems: Organizational and market factors.* Presented at the AcademyHealth Disparities Interest Group Meeting, Orlando, FL. Retrieved from http://www.academyhealth.org/files/interestgroups/disparities/weech-maldonador.pdf
Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation.* Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf
Wu, E., & Martinez, M. (2006). *Taking cultural competency from theory to action.* (Commonwealth Fund Publication No. 964). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf
Wynia, M., Hasnain-Wynia, R., Hotze, T. D., & Ivey, S. L. (2011). *Collecting and using race, ethnicity and language data in ambulatory settings: A white paper with recommendations from the Commission to End Health Care Disparities.* Retrieved from American Medical Association website: http://www.ama-assn.org/resources/doc/public-health/cehcd-redata.pdf

Office of Minority Health
U.S. Department of Health and Human Services
1101 Wootton Parkway, Suite 600
Rockville, MD 20852